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ABSTRACT

This final report discusses the activities and outcomes of the Early Intervention Specialist Program, a preservice personnel preparation project designed to develop, implement, and evaluate a new interdisciplinary certificate/credential process for early interventionists providing services within Connecticut's early intervention system. The certificate program consisted of 15 credit hours, 9 credits of coursework and 6 credit hours of supervised practicum experience. The course content of the project contained three modules: families of infants and toddlers, interventions through teaming and interagency collaborations, and systems change. The second feature consisted of a supervised practicum experience based upon a series of 41 competency-based tasks used to measure the trainee's acquisition and application of critical content taught in the modules. These competencies included areas such as family and child assessment, Individualized Family Service Plan development, child intervention and service delivery, assistive technology, community resources, teaming, and interagency collaborations. An important feature of the program was the identification of peer mentorships as an effective method of training. The report discusses project goals and objectives, theoretical frameworks, logistical problems, results, and impact. Extensive appendices include information on curriculum content, competencies, supervisory materials, training manuals, and evaluation instruments. (Contains 46 references.) (CR)

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Preservice Training of Pediatric Residents and Early Interventionists

FINAL REPORT

ED 448 559

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Office of Special Education Programs
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ABSTRACT

Preservice Training of Pediatric Residents and Early Interventionists: The Early Intervention Specialist Project

An Early Education Program for Children with Disabilities Project

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Director

Gerarda A. Hanna
Coordinator

The Early Intervention Specialist Program was originally funded for three years (January 1997 through December 1999, obtaining a six month extension through June 2000. The preservice personnel preparation project's purpose was to design, implement and evaluate a new interdisciplinary certificate/credential process for early interventionist (across disciplines) providing services within the Connecticut's Part C system.

The project in conjunction with Connecticut's Lead Agency, The Department of Mental Retardation, provided an opportunity to enable Connecticut to begin to develop a Comprehensive System of Personnel Development (CSPD) that would eventually create and lead to an interdisciplinary program for early intervention specialists who have met the highest professional standard in their disciplines. All of the projects efforts were coordinated with state agencies and other federal grant projects designed to improve the capacity of a state's (specifically Connecticut's) early intervention service delivery program.

The certificate program consisted of fifteen credit hours, nine credits of coursework and six credit hours of supervised practicum experience. The course content of the project consisted of course work designed to be taught in three modules: Families of Infants and Toddlers, Interventions Through Teaming and Interagency Collaborations and Systems Change. The second feature consisted of a supervised practicum experience based upon a series of forty-one competency-based tasks used to measure the trainee's acquisition and application of critical content taught in the modules. These competencies included areas such as family and child assessment, IFSP development, child intervention and service delivery, assistive technology, community resources, teaming and interagency collaborations. Competency completion was evaluated on materials collected in a portfolio format, clinical site observations, a self reflection process and completion of observation checklists by university supervisors and/or peer mentors. An important feature of this component was the identification of peer mentorship as an effective method of training.

Two levels of system support were provided to the project, first, an advisory board of personnel involved in the development and evaluation of an interdisciplinary competency based credentialing process for infant-toddler specialist in other states assisted Connecticut in addressing a strategic plan on developing a credential system. Finally, through collaboration with Connecticut's Early Intervention Interagency Coordinating Council (ICC), a standing committee and sub committees were formed, in particular, a Higher Education Council was established to build long term capacity of CT's universities and colleges and to continue the certification process in early intervention in Connecticut.

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1.3 Meet with project consultant
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1.5 Refine methodology
1.6 Refine competencies
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I. PROJECT GOALS AND OBJECTIVES

The goals of this project were to: 1) design, implement and evaluate a new interdisciplinary certification/credential process for early interventionists under Part C to meet the highest standard of professionalism in their disciplines and; 2) to address the need for instituting standards and requirements for certification under Connecticut's Part C system and the capacity of Connecticut's universities and colleges to provide preservice training.

The components and activities of this model focused on the design of a training program based upon a statewide needs assessment and an individual self-assessment, implementation of course content and objectives during class and course work activities, completion and supervision of core competencies in everyday practice and various methods of student evaluation of course content and demonstration of core competencies in portfolio format.

Objective 1.0 To develop a preservice personnel preparation program: To ensure that activities were designed and completed as scheduled and that there was maximum coordination with each objective of the project.

Activity 1.1 Assess training needs.

Statewide needs assessment: A comprehensive needs assessment was developed to begin to address the content of the module curriculums. The tool was based on the national instrument, Project PANAMS, with modification to meet the needs of Connecticut. Provider staff training needs were examined in nine competency areas, policies and procedures, assessment, family centered care, teaming, individualized program, service delivery, communication, collaboration, transitions and technology. Statewide assessments were distributed to all of Connecticut's Birth to Three program administrators and early intervention providers. A copy of the statewide assessment is in Appendix A.

Participant self assessment: A participant self assessment tool was designed for enrolled trainees to complete based upon educational and professional experiences with the program's four components of the core competencies including family, intervention, service delivery and environment. The self assessment asks each trainee to rate themselves from ("I have never heard of this competency") to ("I have experienced this many times, can apply it, and have refined my skills in this area"). The self-assessment tool was used as a pre/post evaluation tool and also to assist the trainee in designing individual adult learning action plans to accomplish each criteria task described in the core competencies. A copy of the participant self-assessment is in Appendix A.

Activity 1.2 Convene advisory board: Collaboration of this project with Connecticut's Lead Agency, The Department of Metal Retardation, and its Comprehensive System of Personnel Development began with the convening of an advisory board in September of 1997 for a day long conference. The advisory board consisted of representatives from five states, North Carolina, Kentucky, Virginia, Illinois, and Massachusetts who presented guidelines and certification requirements for each of their states. Key stakeholders in CT's Birth to Three system including lead agency personnel, Interagency Coordinating Council (ICC) representatives, regional directors, higher education personnel and early interventionists enrolled in this project were in attendance. Outcomes of the conference focused on a common understanding of the development and implementation of the credential process in other states and a recommendation of CT's lead agency for the possibility of a credential process for service providers under Part C. Summary of the conference is included in Appendix B.

Activity 1.3 Meet with project consultant: Communication was ongoing with the project consultants throughout the three years (1997-1999) of the grant. Consultants Molly Cole and Gabriela Freyer were instrumental in providing guidance during the Family Centered Care module. Gabriela Freyer presented issues dealing with culture competency and early intervention strategies. Molly Cole participated as a co-teacher with a special emphasis on parenting issues with children who have special health care needs.

Activity 1.4 Refine curriculum content: The curriculums for the project were divided into three modules, each with their own objectives, topics outlined in syllabus form, and bibliographies. Each module was refined yearly, adding the latest in current research and best practices in the field of early intervention. Families of Infants and Toddlers, Module One, focused on the diversity of families, their priorities, concerns and resources, understanding family systems theory, the development of the Individualized Family Service Plan and family assessments and interview protocols. Specific emphasis focused on parent child interactions, data collection and communication techniques. In 1999, this Module was offered as a three-credit course for the University of Connecticut's Master's in Public Health Program. The objectives for Interventions in Teaming included individual and external influences on the team process and facilitating problem solving within members of the team. Specific areas included, creating integrated goals for service delivery and utilizing consultative models and conflict management techniques within the teaming process. The third module focused on Interagency Collaborations and Systems Change. The course identified facilitators and barriers to collaboration, focused on the skills of the service coordinator to create strategies to partner families with community settings and developing system change strategies for improving early intervention. For this module, project trainees collaborated as a group to teach class on a chosen topic requiring outlines, presentation materials, resources and a reference list. Course objectives, schedules and bibliographies for each module are located in Appendix C.

Activity 1.5 Refine methodology: Module content was taught in four-hour sessions during an eight-week semester. Session content was taught through videos, small discussion groups, role-playing activities involving case studies and lecture within a group discussion context. In order to individualize learning and foster adult learning skills, trainees chose bibliography readings relating to each module topic and were responsible to develop written reactions to readings, discussed in small peer groups and the larger class sessions. Parents of children with special needs who worked in early intervention systems were recruited and shared experiences in class sessions with co-trainees about their early intervention programs or special health related or educational topics. Guest speakers who were parents of children with special needs related personal experiences to emphasize the importance family centered principles and interventions in natural environments. During years two and three, instruction included graduates of the certificate program to assist in the presentation of topics and lend their experience to trainees and in evaluating and implementing theory presented in class to everyday service delivery.

Activity 1.6 Refine competencies: The project's competencies were based on integrated tasks that the trainees perform in their role as early interventionists. The tasks were designed to ensure carry-over of program theory and content to practice but were separated into forty-one separate criteria to illustrate the complexity of service delivery and the skill development necessary to implement best practice in early intervention. Competencies were amended to reflect individualized completion, refined to include additional skills and integration of tasks and reflected new areas of research into practice, such as learning opportunities and natural environments. In addition, the program coordinated several of the competencies with Component Two of the grant, meeting with pediatricians to share experiences and collaborate on best practices in family-centered care and early intervention strategies. Competencies were continually updated to reflect current early intervention terminology. These competencies were used by the standing committee of Connecticut's ICC to develop professional standards for a credentialing system for the Birth to Three system. See Appendix D for the list of competencies.

Activity 1.7 Organize and schedule clinical practica: Practicum action plans for each trainee were developed individually in concert with adult learning theory principles. Each trainee signed a written plan in the form of a contract with the supervisor stating the competencies that would be completed during each module as well as the number of contacts with program supervisors and/or peer mentors. Each trainee used the supervision, peer mentor or a combination model in the clinical modules. All trainees were assigned a university supervisor, as well as receiving some level of supervision from their program administrator. Meetings were held with each program administrator and university supervisor to discuss expectations and standards of performance when supervising students. Each trainee met with supervisors on a monthly or bi-monthly basis to update progress, define goals and review competency criteria that had been completed. In order to facilitate communications and research information necessary to complete competencies, the University of Connecticut's Child and Family

Studies Library opened two Saturdays per month during 1998-1999 years. During these two years, the university project coordinator scheduled Competency Workshops to facilitate completion of tasks, portfolio makeup and group collaboration. Topics were repeated three times at a north central, south central and central part of the State in order to meet the demands of trainee's schedules and regional groups of students. The project coordinator was assisted in presentation of material by two teaching assistants that had graduated from the certificate program in 1997. A copy of all supervisory materials are included in Appendix E and explained in detail in the Student Handbook, Appendix F.

Activity 1.8 Develop training manuals, materials and evaluation instruments: Program orientation materials were developed consisting of forms and schedules pertinent to Module One. Training manuals included a Student Handbook, updated each year and a Supervision and Mentorship manual, defining practicum responsibilities. Evaluation instruments developed during the project included action plan recording forms, observation checklists for competencies, consumer satisfaction surveys for class sessions, modules, supervision and mentorship experiences. A participant entry survey, a competency self-assessment form, a program evaluation form listing criteria ratings to guide supervisors on evaluation of competency completion were developed. A brochure of the project was developed to recruit participants. All materials are located in Appendix F.

Activity 1.9 Recruit and admit students. The project targeted early interventionists currently employed in the Birth to Three system to enroll in the program. A brochure was developed and printed explaining the purpose and content of the program. Marketing for participants encompassed word of mouth, distribution of flyers and brochures. Flyers are distributed to all participants who attended training workshops held by the Division of Child and Family Studies and Department of Mental Retardation service coordination, personnel development training and Statewide Infant Toddler Forums. An initial telephone call was made and letter sent with brochures to each of the 38 program directors in the CT Birth to Three System. Each director was asked to pass out brochures to each of their staff members. The project coordinator also requested to attend staff meetings to discuss and explain the program to each provider agency. Any responses to the program were followed up with a telephone call by the university project coordinator and a more elaborate written description of the program and an application were mailed to the interested individual. The application form consisted of demographic information, previous work experiences and current certifications, a statement of motive, and a supervisor's recommendation. Every applicant was interviewed by the university project coordinator or teaching assistant regarding their interests in the program, specific learning objectives and their perceptions of early intervention. Parents of children with special needs were particularly recruited to enter the program as co-trainees to share their unique experiences with classmates. Trainees were enrolled in training without any stipulations in regard to their nationality, race, color, language, age, religion, disability, S.E.S., etc. Accommodations were made to assist persons with disabilities enrolled in the program. A copy of the brochure, letter to provider agencies, interview format and application are included in Appendix F.

Activity 1.10 Schedule modules, seminars and meetings: A trainee orientation to the program's content and requirements, including an overview of the academic year occurred during the first month of each grant year. The trainees had an opportunity to meet the Director and University Project Coordinator and other trainees. Interested participants were invited to attend although they had not made a final decision to commit to the program. During orientation, participants completed the entry survey to compile participant information, the competency self-assessment/pretest, and a contract specifying their responsibilities in the program. The Student Handbook, competencies and Supervisor/Mentorship training manual were handed out. Due to difficulty in having enough participants in regional areas to schedule videoconferencing, all participants were taught at the Division of Child and Family Studies in Farmington, instead of regional groups. The majority of participants requested weeknights for class instead of weekdays due to job responsibilities and lack of release time from work schedules. To decrease the driving time for participants, classes were scheduled for four hours, every other week. Trainees in conjunction with the project coordinator scheduled clinical workshops, practicum observations and meetings with supervisors around work commitments and Saturdays. Orientation materials are located in Appendix F.

Objective 2.0 **To implement a preservice personnel preparation program:** To ensure project and quality of project design.

Activity 2.1 Implement modules: The three modules were each implemented over the three year grant period from January to December. During 1997, thirty-six class sessions were completed due to the number of trainees enrolled in the program. Twelve eight hour sessions were held every Saturday to accommodate trainee's requests for less travel and evenings away from home. For 1998 and 1999, twenty-four sessions were held, every other week from January to December, lasting four hours each. Modules for these years were implemented using an instructor didactic process which stimulated and facilitated group discussion, creative thinking and problem solving among participants. Case studies, role-playing, videos and guest speakers supplemented instruction. Co-instructors who were family members of children with special needs were instrumental in providing opportunities for the trainees to listen to issues that were important to family centered practices and to apply these to in early intervention service delivery during role-playing sessions. The 41 competencies were embedded into the coursework and readings assigned weekly. Up to nine Continuing Education credits were awarded per trainee who completed each module.

Activity 2.2 Utilize home and school visits: Trainees implemented the clinical practica competencies within the early intervention provider program in which they were employed. The trainees implemented the competencies during home visits and/or other natural environments during regular work hours. Trainees who did not have clients or professional positions that gave them the availability during work hours to implement competencies asked and requested parents with children identified with special needs to volunteer their expertise with them in accomplishing the competency objectives. Reflections, summaries of tasks and portfolio compilations were completed outside work hours.

Activity 2.3 Utilize instructional technology: Videoconferencing was not implemented due to the numerous requests for the use of the university downlink by other programs and the cost effectiveness of the number students in regional areas that the downlink would reach and serve. Also, trainee's lacked the availability of computer technology, Email and access to the Internet.

Activity 2.4 Implement seminars: All trainees were invited to the seminars sponsored by the physician component of the grant. Seminar topics include, "Learning and Using the Legislative Process, " "Coordinating Resources in Our Community," "The Importance of Hope," "Impact of Domestic Violence on Children," and "The Hospice Experience." Many of the trainees attended these seminars.

Activity 2.5 Supervise clinical practica: The students were required to complete clinical practicum experiences that required site observations. The university project coordinator, provider agency administrators, certificate graduates and peer mentors provided supervision during clinical practica for all three years of the grant. Clinical practica included facilitated workshops, service delivery during work hours, or peer mentor groups. The university project coordinator was responsible along with the trainee in concert with adult learning principles to develop action plans, goals and written timelines for completion of competencies. Bi-monthly meetings were required between supervisors and trainees to review progress and tailor goals to individual needs. For each competency, an observation, checklist or evaluation form was completed. The supervisor or peer mentor rated a checklist on a six point scale for each trainee upon final observation or review of written materials included in the portforlio. Each trainee was also required to include a self reflection on each activity to reflect upon what they have learned and skills that can be improved upon. Each trainee was required to pre-conference and post-conference with their supervisor. Review of each competency criteria was reviewed by the university project coordinator for completeness prior to inclusion in the trainee's portfolio. Due to the vast differences in experience in the class, participants were encouraged to tailor and modify competencies to fit their individual interests and provide new challenges. These modifications or substitutions had to be approved by the participant's university supervisor before implementing the competency. In an effort to provide interdisciplinary experiences, trainees attended several Component 2, Physician Didactic sessions. These sessions include Early Intervention, Roles of the Professional and The Legislative Process. The trainee in early intervention lent their expertise in providing examples of their roles as providers of services and how state and federal regulations impact the delivery of services for children with disabilities. At least one observation per month was required to be scheduled with supervisors to ensure skills are being carried over into practice.

Activity 2.6 Implement state and local board participation: Connecticut's ICC addressed by standing committee and sub committees, the design of the credential process and competencies for the Birth to Three provider program supervisory personnel, educator, interventionists and paraprofessionals. The lead agency in concert with Connecticut's legislators continues to address the credential/certification issue, refine competencies and move forward on state standards. See Appendix G for diagram for the ICC and CSPD credentialing structure.

Activity 2.7 Convene Higher Education Council: The Higher Education Council functioned as a sub-committee of the Connecticut's CSPD Standing Committee to address preservice issues. Its members, as part of Connecticut's colleges and universities, will continue to address long-term capacity of training early interventionists. The Committee had met quarterly and continues to provide expertise on the evaluation of the CT's CSPD credentialing process, of which the competencies developed by this grant were used as a basis to model the state standards.

Activity 2.8 Facilitate competencies: Several steps had been taken during the three grant years which facilitated each trainee's organization and completion of competencies. The university supervisor met monthly or bi-monthly with each trainee to plan goals and review progress of meeting those goals. Practicum plans were written for each module at that time. Research articles and library references were made available to the trainees on an ongoing basis to facilitate written review of materials. The Division of Child and Family Studies' early intervention library opened two Saturdays a month to accommodate student groups who collaborated and teamed on several of the competencies. Teaming was encouraged on the following competencies, seizures and medications, child assessment review, curriculum evaluations, family assessment reviews, state and federal regulation and community services and resource mapping. Mentor relationships were encouraged for competencies, feeding, handling, positioning and assistive technology. Mentoring and pairing less experienced trainees with more experienced trainees were encouraged and facilitated by the university supervisor. Students were counseled to design a plan to combine relevant program tasks together, such as family interview, IFSP family outcomes and objectives, IFSP writing and facilitation of an IFSP or team staffing meeting. Competency based workshops offered the trainees a way to assist them to work together as a team, share resources and network to complete the criteria tasks.

Objective 3.0. To evaluate a preservice personnel preparation program: To evaluate the implementation of activities.

Activity 3.1 Evaluate student status: The major evaluation tool for evaluating student status and progress was the completion of competencies for the certificate. Each competency required evidence in portfolio format that contained a systematic collection of documents illustrating knowledge, experience, progress and skills for each of the 41 criteria tasks. The portfolio focused on self-assessment and reflection while translating knowledge into applied field based practices.

Pre/Post Assessment of Program Competencies. Prior to beginning of the program, the enrolled participants completed a self-assessment of their experience with the program competencies. The competencies were divided into four categories family, intervention, service model, and environment. This information was evaluated by charting frequencies of responses and mean scores relative to topic, education level and experience. All trainees who completed the program were then post-tested and results compared with the initial self-assessment. Trainees rated their progress at the end of the program showing significant increases when measured with pre-test assessment results. Trainees completed each competency criteria task by a process of supervision, self reflection and preparation of materials to include in a portfolio. Completion of a Competency Checklist by either a supervisor or peer-mentor to include in the portfolio, evaluated knowledge obtained. Each of the trainees who had competed all competencies reported and documented over 300 clinical hours to complete the tasks.

Assessment of Individual Module Objectives. Students also evaluated each session of course work to assist the faculty in improving content, techniques for delivery and practice activities. The course work presented during class was extended through competencies and site participation. Objectives were embedded within the competency criteria and completion of tasks. Trainees were required to develop and write reading reactions based upon required topic references which were graded by the University project director with scores from 1-5 relative to critical thinking. Trainees utilized self-reflections as a means of understanding and processing objectives of course content during practicum. Consumer Satisfactions were completed by session, module and evaluated by overall topic.

Completion of Clinical Practicum. Completion of practicum and site participations were designed so trainees practiced new knowledge and skills learned during work routines. The evaluative components of the program were measured through the number of contact hours the student had with their supervisor and action plans for each criteria task per competency. Plans were reviewed each month for progress and/or revision. Observations were scheduled bi-monthly with each trainee during his/her work hours and caseloads. Each program competency task was accomplished when the program supervisor reviewed all materials and signed off on the competency Overall Rating Sheet. The following forms were used to compete the evaluation process. The practicum action plan assisted the trainee to organize and preplan the implementation of the task, document the sequence and resources needed to accomplish the task and plan adaptations for future implementations. This form helped the student track the overall time to accomplish the entire competency. The contact log helped students organize and reinforce the small steps completed by documenting total time and types of contacts made with teams. Practicum logs documented all activities and reflections regarding new knowledge and new techniques to promote self-evaluation. Trainees were required to develop a plan, pre conference with a supervisor and then post conference after the visit. Observation/Performance checklists were developed for each task and completed by either a supervisor, peer mentor or family that had been visited on the quality of his/her performance. The checklists were part of the portfolio format as were reading reactions, class bibliographies, written summaries and supervisory materials.

Activity 3.2 Evaluate program status

Demographic Data. Enrolled participants were also asked to complete an entry survey, requesting background information on extent of knowledge and experience about children with disabilities, their primary roles and factors involved in choosing the early intervention field. Most participants described themselves as direct service providers with undergraduate degrees in special education or a related field. The majority of participants stated that the reason for attending the program was to become better informed about early intervention but that home responsibilities, job responsibilities and attending evening classes were most problematic in considering to attend.

Consumer Satisfaction of Modules. All modules sessions were completed during the three years of the grant. Continuing Education Credits were awarded to certified educators for session attendance as well as clinical hours. A five-point likert scale (1=strongly disagree, 5=strongly agree) determining participant satisfaction with each session was completed by each trainee at the end of each class session. The sessions were evaluated on presentation and content. Satisfactions with session for topics overall were completed as well as module satisfactions at the end of each module. At the end of the three year grant, trainees who had completed all of the forty-one competencies evaluated peer mentors and supervisors.

Activity 3.3 Evaluate community status:

Agency/Parent Satisfaction: The specific geographic are for the implementation of the program was the entire state of Connecticut. The Birth to Three system consisted of five regions with thirty-eight individual provider agencies. The lead agency for the system, the Department of Mental Retardation, supported this project as one avenue towards developing a comprehensive personnel development program. The response to the project by the agency providers to the formal training was positive. Provider administrators participated in recruitment efforts and encouraged their personnel to attend. However, only one agency allowed work time release to prepare for class sessions or complete formating of the portfolio process. One agency refused to allow the university project supervisor to accompany her personnel on home visits. Seventeen out of the thirty-eight provider agency employees or contracted personnel participated in the project. Families of children with special needs who participated with the program supervisors and trainees during home visits supported the project and expressed that they were more than willing to provide assistance to meet the needs of better training programs for early intervention. This information was confirmed by the university supervisors when attending the home visits with trainees. No formal agency/parent satisfaction questionnaire had been developed. This project coordinator was part of the credential sub-committee of the CSPD and in close contact with agency providers that referred and encouraged trainees to attend the program.

Survey of Infant Programs. This survey was in the process of being developed at the beginning of the carry over year 2000 when this project coordinator moved to the state of New Hampshire.

Higher Education Training Council. This council continued to meet quarterly as part of the State's CSPD to develop long term capacity for Connecticut's university and college undergraduate and graduate programs to train early interventionists.

Activity 3.4 Evaluate project status:

Credential Program. This project, in conjunction with the State's ICC, provided a model and impetus to develop a statewide credential for the early intervention system in Connecticut. During the three years of the grant, the project director, who was then chair of the ICC and the project coordinator participated in all aspects of the ICC's standing committee's sub-committees of the CSPD effort to develop a set of competencies for the credential. This project's competencies were a basis for the competencies that were being developed for the statewide credential.

Module Satisfactions. Trainees evaluated each session of coursework by completed consumer satisfactions on the program after each module with comments concerning their level of learning and knowledge gained including how the coursework and competencies had changed their practices with families and children. These assisted the faculty in improving content, techniques for delivery and practice activities.

Certificate Program. This program, upon completion of the course work and competencies issued two separate certificates of completion. The University of Connecticut, Division of Child and Family Studies, Department of Pediatrics issued forty-three Certificates of Completion of Coursework and thirteen Certificates of Completion of Competencies over the three-year period. The Department of Mental Retardation, lead agency, had indicated that these certificates would be recognized as attaining the highest level of professional standard in the State's CSPD system for service delivery in early intervention.

II. Theoretical Framework

Purpose

The purpose of the Early Intervention Specialist Program was to develop, implement and evaluate a preservice personnel preparation program at the University of Connecticut School of Medicine, administered by the Division of Child and Family Studies, Department of Pediatrics. The goal of the program was the preparation of early intervention personnel. This was a new preservice interdisciplinary, competency based program focusing on the improvement of early intervention services to families who have infants and toddlers with special needs in Connecticut.

The program was significant because the training content and portfolio process specifically addressed the task of increasing the number of qualified personnel available to implement early intervention services that must be addressed by all states under Part C. The programmatic requirements of this law has included the establishment of a Comprehensive System of Personnel Development(CSPD) and the adoption of personnel standards. While these are only two of the fourteen service components which are required of the States participating, they represent a critical area which must be addressed before each state can be assured of its ability to implement the full scope of services required by the law (Bruder & McCollum, 1992).

The unique needs of infants and families eligible for early intervention have created a challenge to service providers. Both federal legislation (P.L. 99-457), and recommended practice (Brewer, et.al., Shelton, Jeppson, & Johnson, 1987), now suggest that early intervention programs be family-centered, comprehensive, community based and coordinated across disciplines and agencies. State and local service agencies have continued to struggle with the development of early intervention programs which encompass the above mentioned characteristics. In designing such services, a great number of variables must be address (cf. Woodruff, McGonigel, Garland, Zeitlin, Chazkel-Hochman, Shanahan, et al., 1985).

It had been document that early intervention is facing a critical shortage of personnel trained to provide services under Public Law 99-457 (Graham & Bryant, 1993; Meisels & Provence, 1989; Winton, 1996). In particular, data have been collected on shortages within special education, occupational therapy, physical therapy, nursing and speech and language pathology (Bruder, Lippman, & Bologna, 1994). Additionally, the Bureau of labor Statistics (1988) has estimated employment growth rates of 36% for early childhood teachers and 42% for health professionals by the year 2000.

In examining the current status of training programs for professionals specializing in early intervention, criticism has been leveled at the type of preservice training which was available to both undergraduate and graduate students. Courtnage and Smith-Davis (1987) conducted a survey of 260 undergraduate programs in special education and found that 48% of them did not offer coursework on interdisciplinary team functioning. Likewise, Bailey and his colleagues (Bailey, Palsha, & Huntington, 1990) surveyed both undergraduate and graduate programs for disciplines listed within Part C of IDEA: special education, nursing, occupational therapy, speech and language pathology, physical therapy, audiology, nutrition, psychology and social work. They examined the number of hours of training content available in areas to be provided under the law. These areas included case management, ethics, infant development, infant and family assessment, team processing and values. Their results suggested a significant lack of preparation within these areas by the higher education programs that responded to the survey. Additionally, of those higher education personnel preparation programs that specifically train infant specialists on content required by the law, there had been a lack of consensus over the type and number of competencies a trainee should exhibit. An examination of federally funded personnel preparation programs for interdisciplinary infant specialists found that there was a range of 7 to 380 training competencies to be demonstrated by students within 40 funded programs (Bruder & McLean, 1988).

The lack of available, appropriately trained personnel has been compounded by a lack of professional standards specific to early intervention services. The requirement for Part H, (Part C) for professional standards across the disciplines involved in early intervention did not result in any nationally adopted specialized requirements. Only seven states (Arkansas, Massachusetts, North Carolina, Ohio, Missouri, Montana, and South Carolina) have adopted specialized standards for certain personnel categories serving infants and toddler and their families (Bruder, Klosowski, & Daguio, 1991); (Striffler, 1995). Other states have begun to implement and evaluate credential requirements for all early interventionists (cross disciplinary). However, these states are few.

Many articles have attempted to respond to the changes in service delivery created by the law by proposing specific training recommendations for the professional disciplines involved in early intervention (Campbell, 1990). These disciplines include special education (Bailey, et al., 1990; Burton, Hains, Hanline, McLean, & McCormick, 1992; Lowenthal, 1992; McCollum, McCartan, McLean, & Kaiser, 1989, Miller, 1991; McCollum & Stayton, 1996; Odum, McLean, Johnson & LaMontagne, 1995), physical therapy (American Nurses Asociation, 1990; Scull & Deitz, 1989), social work (Nover & Timberlake, 1989), occupational therapy (Hanft & Humphry, 1989) nutrition (Kaufman, 1989), psychology (Drotar & Sturn, 1989) and medicine (Brewer, et al., 1989). The content proposed within these articles include discipline specific skills in both infancy and families, as well as interdisciplinary and interagency skills necessary for the implementation of the law (Thorp & McCollum, 1994; Widerstrom & Bricker, 1996).

For example all disciplines should have thorough knowledge of infant development, identification and assessment strategies, intervention techniques, family system, and communication skills. These skills would also include functioning within a team by sharing and utilizing other member's expertise for both assessment and program planning (Bailey, McWilliam, & Winton, 1992; Bruder, 1995). Additionally, all disciplines should have a working knowledge of interagency coordination and service coordination strategies as required by Part C of IDEA (Bruder & Bologna, 1993). It must be noted that many of these skills require supervised practical application in order to insure the trainee acquires competence in these areas (Bruder, Brinckerhof, & Spence, 19910; Bruder, Klosowski, & Daguio, 1991; Bruder, et al., 1994; Bruder & Nikitas, 1992).

Need for Project

Connecticut has struggled to implement the requirements of Part C of IDEA. Connecticut began full implementation of early intervention services on October 1, 1993 when the State Department of Education was the lead agency. In 1996, a bill passed to change the state lead agency for early intervention to the State Department of Mental Retardation (DMR). This was due to a number of issues, most importantly whether or not to continue participation in the federal Part H (now Part C) program. The bill passed (CT 96-185) was modeled after the federal Part H (now Part C) program.

Under this legislation early intervention services have been provided to eligible infants and toddlers and their families by a variety of programs and agencies. At the start of the grant, the Department of Mental Retardation provided services to approximately 931 infants and toddlers with disabilities through six regional programs. (Presently, that number has risen to approximately 2,500). The State Department of Education provided services to all referred infants and toddlers through six regional education service centers through the provision of service coordinator which ended June 31, 1996. Private non-profit rehabilitation centers provided services to approximately 800 infants and toddlers. Private agencies and therapists also provided services though exact numbers were unknown.

Beginning July 1, 1996 services for infants, toddlers and their families were provided by 33 public (DMR) and private agencies across five service delivery regions. (Presently, there are 38 agencies providing services). Each region has a Part C regional director. The entry point for families into the early intervention system is an 800 telephone number at Connecticut INFOLINE through which a referral to early intervention can be made. The service delivery system continued unchanged under the new legislation: however, service coordination became the responsibility of individual early intervention service providers. This included hospital or health care personnel. It was estimated that the system had over 500 service providers, and data on their competencies and background in early intervention was nonexistent. The data that did exist revealed needs across many areas of early intervention, such as the development and implementation of IFSPs. For example, a research project at the Division of Child and Family Studies documented that across all outcomes in 182 randomly selected IFSPs, 3% mentioned the family. None contained progress data. (Currently, there are approximately 700 service providers, both full and part time serving children and families).

Likewise, data on early intervention services in Connecticut was limited as a statewide data system for Part C had many problems. The state, like many, does not serve at risk infants or toddlers, but focuses its resources on those children who have a diagnosed or established condition which may lead to developmental delay and those children who are developmentally delayed (by a standardized assessment tool, two standard deviations below the mean, or clinical judgment). It should be noted that early intervention programs in Connecticut reported a count of 2,430 infants and toddlers receiving services at that time. This count was across programs (as many children are in one or more programs) and no service records were readily available on children or families.

The State of Connecticut had not implemented a comprehensive CSPD for Part H (Part C) since its full involvement in 1993 at the initial writing of this grant. While personnel preparation activities have been undertaken by a variety of agencies for a range of audiences, early intervention system activities have not been responsive to best practice guidelines in training (e.g., competency based, follow-up). In addition, a CSPD process specific to the regulations (e.g. team models, family centered models, interagency collaborative models) had not been developed, nor implemented using the components included in federal regulation.

A small task force consisting of twelve people met for two days in Connecticut in 1994 to brainstorm areas of content which should be included in training for the comprehensive system of personnel development (CSPD). The project director for this grant was a participant at this two-day meeting. The content areas were not meant to be competencies, yet they were labeled as such and were used as a draft document to justify the CSPD in 1995. However, these areas had not been systematized into a needs assessment, nor had preservice or inservice activities been designed to meet these areas in a systematic manner.

As all states, Connecticut requires the highest degree/licensure level for interventionists across the disciplines providing Part C services. Special educators have been eligible for a certificate at a Bachelor's level for teaching children age birth through eight, available in 1988 at two institutes of higher education. No other disciplines have been required to have an age specific focus with their licensure. There has not been a preservice degree, bachelors or masters program in early intervention in any college or university in Connecticut since 1989. At that time, there was one specialized master's program in special education at the University of Connecticut in Storrs. There was a nine to twelve graduate credit interdisciplinary infant certificate offered by this project director from 1987-1990 the University of Connecticut School of Medicine, Department of Pediatrics. Forty-two students graduated from this program (Bruder, Brinckerhoff, & Spence, 1991), and components of the program were embedded into graduate training programs at the University of Connecticut Storrs (PT), University of Hartford, (OT, psychology), Central Connecticut State University, (education), Southern Connecticut State University, (speech and language), and Quinnipiac, (OT and PT) through activities of a Higher Education Training Council. The certificate program endorsement was dropped by the lead agency in 1990.

III. MODEL DESCRIPTION

Design

The purpose of the Early Intervention Specialist Program was to create a new fifteen-hour preservice personnel preparation certificate program to be completed in one year for early intervention specialists. The program was offered to all practitioners, across disciplines, in the Connecticut early intervention system. It was interdisciplinary (both instructors and participants), team based and involved parents of children with disabilities as teachers and supervisors. It was designed to utilize technology as an instructional support (e-mail, Internet, and video conferencing) and both a peer mentoring and supervisor system for completion of practica and follow-up. The program provided an integral component to Connecticut's evolving CSPD, under the 1996 legislation. The lead agency indicated a strong support for the project, as they anticipated requiring all early interventionist to complete a certification process in order to provide early intervention in the State of Connecticut, beginning late 2000.

The fifteen credit competency based project was implemented throughout the state of Connecticut by an interdisciplinary faculty to all professional personnel who met entry level licensing or certification in their field and were employed in an early intervention program. The preservice program resulted in an early intervention certificate or credential, which is anticipated to become a part of the evolving Part C CSPD. Program competency tasks were used to structure the content and methodology of the program. The first activity was the development of a needs assessment corresponding to the competencies.

The early intervention certificate program consisted of coursework of three modules of three credits each. Each credit consisted of a minimum of ten hours of contact time, therefore each module required at least thirty hours of contact time. Additionally, the certificate required two clinical practica. The practica, each three credits, or a total of sixty hours of supervised time.

Content

The content of the certificate program was delineated into three modules, each of three credits. The first module was Families of Infants and Toddlers, the second module was Interventions in Teaming and the third focused on interagency collaboration and systems change. These modules were designed as a course syllabus with the background information, objectives, a schedule and agenda for each session, references, readings and competencies. Families of infants and toddlers included family systems theory, families with special needs, the role of social support, resiliency, family assessment, assessment protocols, implementing the IFSP, evaluation models and ethics. Interventions through Teaming contained topics such as types of teams, working across disciplines, team process and problem solving, communication strategies, team maintenance strategies and team tasks. Natural environments and learning opportunities were discussed as a component of team context. Content included the developmental areas of cognition, communication, motor, adaptive, self help and social competence and play in team context and intervention. Assessment protocols across disciplines, contexts, disabilities and families were included. The last module focused on building community collaboration, creating a program philosophy and identifying the role and responsibility of the service coordinator in community collaboration.

Methods

The content of the modules was taught by faculty consisting of this project director, university presenters and co-taught by parents who have children with special needs, which has been a practice used by the project director since 1987. All modules consisted of eight four hour sessions or four fulls day containing eight hours of instruction. In addition, all class sessions had interdisciplinary facilitators. The sessions were scheduled at times and days convenient for participants which included Saturdays and evening classes. Sessions were participant driven, and included case studies, application of theory and content, individual and group activities and discussion, all utilizing adult learning techniques (Bruder & Nikitas, 1992). The third module was taught by the trainees themselves in a collaborative effort based on adult learning activities. Topics were chosen, objectives, agendas and references were required and each group delivered the presentation.

The project anticipated the use of instructional technology, including video conferencing and the internet to teach content of the modules. This was used on a limited basis due to trainees being located in many difference regions of the state and its expense and availability to each participant.

Clinical Experiences

The trainees were required to complete two separate practicum experiences of three credits each. The first was under the joint supervision of a project faculty and/or their agency administrator. The purpose of this three credit or 30 hour practicum was to complete all competency based tasks not completed through the three modules of coursework. The trainees were required to meet weekly with supervisors for feed back and dialogue. In addition, the student was required to be observed bi-weekly in a clinical routine by either supervisor. Upon completion of this practica, the trainees choose a peer partner with whom they participated in mentorship activities for a second three credit or 30 hour practica. The purpose of the peer mentorship practica was to develop a project relevant to the early intervention needs of the community, again using the competency task as the structure. Evaluation occurred through communication with the program coordinator concerning completion of action plans, contact logs, observation checklists, practium logs and product development through written reviews or summaries which became part of the portfolio format.

Management Plan

The project was directed by Dr. Bruder, who was responsible for the overall integrity of the project and implementation of the module content. The coordinator, Gerri A. Hanna oversaw the day to day responsibilities of the project including the recruitment and scheduling of students, the scheduling of modules and practicum meetings, supervision and collection of evaluation data. Two support mechanisms were used in the implementation of the certificate program which included the advisory board and higher education council, both described in the goals and objectives portion of this report.

IV. LOGISTICS

The project's participant recruitment efforts were directed to persons who were providing services in the Birth to Three system. At the beginning of the project, it was anticipated that the program would reach 120 trainees. For all three years, approximately eighty-five participants initially inquired about the program and attended the orientation project, fifty-seven of these enrolled in the project and began attending module sessions. Forty-three completed the module sessions and course work while thirteen of the forty-three completed all competencies, receiving certificates of completion of competencies. The majority of participants indicated that home and job responsibilities precluded them from completing the course and the competencies. Many non-service professionals inquired and made application to the program. A decision was made by the Director and project coordinator to interview and admit those who worked in other capacities with an early intervention emphasis, such as, a Head Start Director, a director of a child care facility, Child and Family Studies employees, a pre-school speech pathologist, social workers, working in the capacity of service coordinators, and the director of the Birth to Three system's CSPD. Several participants were parents of children with special needs who had no formal training or educational background in early intervention but could lend there expertise and experience to the training sessions and competencies completion. Trainees working outside of the system did not have the opportunities to complete competencies on the job which was anticipated by the project or the licensure to provide service delivery in the system. Classes were also held at the offices of Child and Family Studies. Interviewed applicants that had to travel over an hour to reach class indicated that travel time was too long. Video-conferencing as well as the availability of using the internet did not materialize due to the expense and lack of availability of this technology in regional areas of the state.

V. PROJECT RESULTS

The evaluation component of the grant included a pre-post assessment of overall program content, acquisition of specific module content, completion of program competency tasks, observational measures of professionalism, clinical interaction and a review of the student's portfolio. Consumer satisfaction was measured over course content and the quality of supervision.

Statewide Needs Assessment

A total of 611 need assessments were disseminated throughout Connecticut to all staff and consult providers of the Birth to Three System's comprehensive programs. A total of 142 were returned. Provider needs were examined in nine competencies areas, policies & procedures, assessment, family centered care, teaming, individualized program, service delivery, communication/collaboration, transition and technology. Table 1 indicates that across all respondents, the areas assessed as have little or no knowledge about the subject areas included, technology (66.7%) and service delivery (51.57%). Respondents rated themselves with higher levels of knowledge in areas of teaming (26.29%) and individualized programs (32.38%).

Participant Needs Assessment

Before implementation of the EISP program, seventy-nine enrolled participants who began the module sessions for 1997, 1998, and 1999 completed a self-assessment of their experiences with program competencies within four categories, family, intervention, service model and environment. The tool asked participants to rate experience with each task from a 1 ("I have never heard of this competency") to six (I have refined by skills in this area"). Table 2 reflected the frequency data for all of the three years of the grant.

Table 3 reflected mean scores within each of the four categories and overall range for the three grant years, 1997-1999. The overall mean for all topics was 3.71, family 3.95, intervention 3.83, service delivery, 3.46 and environment 3.52. Service delivery had the lowest mean and in line with these results, over 50 percent of the respondents of the statewide assessment rated themselves as having little or no knowledge in service delivery. Tables 4 and 5 examined mean scores across education levels and years of experience in early intervention, respectively. Higher means were evident for Master's degree participants and 11 to 20 years experience in the field. Table 6 indicated that over eighty percent of the participants were direct service providers and 14.5% had a child with a disability.

The majority of enrollees attended the program to become better informed about early intervention (19.3%), to better understand the birth to three system and work towards solutions (17.9%) and to integrate experience with content (15.3%). Seventy four percent of respondents stated that their knowledge of early intervention was acquired through experience. Table 7. To help get a new job rated the lowest for all three years with .8percent. Home responsibilities were the number one issue affecting attendance of the program (24.1%) Table 8.

Institute Demographics

Figures 1- 3 indicated specific demographic characteristics of the participants. As shown in Figure 1, there is a diversity of specialties entering the program. Special Educators made up the largest segment of attendees (29.5%). Early intervention associates were the next represented with 14,7 percent. Non-early intervention enrollees included daycare directors and managers, home visitors, playgroup organizers, research assistants and parents of children with special needs (8.0%). One enrollee was Connecticut's Comprehensive System of Personnel Development's director and another was seeking her Masters in Public Health Administration. Most of the enrollees had duel roles in the service delivery area, which is not reflected in the data collected.

Figure 2 represented enrollees by years of experience. Most of the enrollees had one to five years of experience (34.2%), 25.percent had eleven to 20 years, 22.4 percent had six to ten years and 15.8 percent had less than one year of experience in early intervention.

Figure 3 described participants by degree, with the majority of the initial participants obtaining Masters level degrees. Of the initial enrollees, the majority described themselves as Caucasian, three African American and two Latino.

Program Competency Completion

Forty-three trainees completed all three modules and received the certificate of course completion. These forty-three trainees were included in the tabulation of the percentage of competencies completed for the three years of the grant. Table 9 indicated the percentage of each competency completed for all years combined. The highest competencies completed were family interview and the visit to the NICU (88.4%). Percentages were higher over all in the family category, family assessment, (79.1%), child care (79.1%), parent child interaction (72.1%), cultural family interview (74.4%), family outcomes, (86.0%) and visit to an institutional setting (Southbury (81.4%). Several reasons could account for higher percentages in this area. The Families of Infants and Toddler module was presented first and each of the competencies tied in with class sessions. Trainees were very motivated and energetic to apply new knowledge and research into practice and more accommodating to adjust schedules to include supervisor visits. Trainees also completed more competencies when done in class sessions or in peer groups, state and federal regulations (65.1%), community roles and knowledge (74,4%), curriculum guides (58.1%), program philosophy (74.4%), service delivery (72.1%) and seizures and medications (74.4%). Two other competency tasks which were completed in line with the family module were IFSP (83.7%), facilitating the IFSP (76.7%) and family service delivery (65.1%). Social competence (32.6%) and home health care (34.9%) were among the lowest tasks completed by the classes. Competency tasks were not deemed to be completed until portfolio materials including self-reflections were submitted and reviewed by the supervisor or peer mentor.

Pre/Post Test

Post-tests were administered to each of the thirteen trainees that completed all competency criteria tasks to measure application of course theory into practice. This was compared to their original self-assessment completed at entrance into the program. Results are indicated in Table 10, showing a compilation of all three years of the grants pre-test means compared to post-test means for forty-one competency tasks. All individual post test means showed gains over individual pre-test results and the combined overall mean was 4.12 pre-test compared to 5.55 for post-test mean for approximately a 2 point gain (1.92). Individual category gains showed an increase of 1.47 gain for the family category, (4.12 pretest and 5.59 posttest) mean results.

Site Observations

The evaluative components of site observations were measured through the number of observation, number of observation hours including conference contacts and number of conference contact hours. This data did not include telephone contact or class contacts. Table 11 and 12 represented the observation/conference contact log kept for 1998 and 1999-year. Peer mentorship hours for the 199 class were kept in individual portfolios but included in the 1998 log. No data was kept on the 1997 year.

Consumer Satisfactions

Students evaluated each course session assisting the faculty in improving content, techniques for delivery and practice activities. The satisfaction with each individual session was based on a 5 point likert scare ranging from 1 to 5, strongly disagree to strongly agree. Sessions were evaluated on presentation organization, knowledge of speaker about subject matter, relevant reading material related to subject matter, opportunities for questions and discussion, variety of methods and techniques utilized, information useful to job, small group activities allowed for problem solving and overall rating of the session. Data is represented in Table 13, Satisfaction with all Topics which includes mean scores for each statement. Higher percentages are evident in the strongly agree category in all statements with an overall rating of the individual topic rated 66.6% and a mean score of 4.63. Eighty one percent of the trainees rated the speaker knowledgeable about the subject and seventy-three percent rated the material presented in the strongly agree category as useful to their job. Table 14 indicated results for all three years for each individual session on an overall rating of topics.

Tables 15 through 18 showed frequency of responses to consumer satisfaction with Modules One, Two, and Three with an overall response to all modules for all three years. Extremely high percentage ratings are evident with module one, Family of Infants and Toddlers with over sixty-eight percent of responses in the strongly agree categories rating faculty and content of sessions. Lower percentages were evident in the areas of maintaining a comfortable pace for learning (34.4%), allowing enough time for questions (43.8%), and time was well organized relative to presentation of content (50.0%). Although ratings were not as high in the strongly agree category for module two, Interventions in Teaming, over fifty-six percent rated each statement in this category. Again, lower rating were evident in maintaining a comfortable pace for learning (48.0%), allowing enough time for questions 48 %), and time was well organized relative to presentation of content (40.0%). Module three, Interagency Collaboration consisted of trainees presenting a topic and rating each others presentations. Over sixty percent of trainees rated their peers in the strongly agree category on all statements with two exceptions; keeping on task (55.0%), and time was well organized (45.0%). All three modules are combined for all three years and represented in Table 18.

On each module satisfaction form, trainees had an opportunity to remark about what they had learned. Comments stated included, " each class I learn more about what EI should look like", "my service delivery has changed to more of a support to the family as opposed to a therapy provider," "I will encourage more consistent teaming in my intervention approach," "my focus has shifted from a child to family focus." One trainee stated that she "became more aware of not being judgmental and more sensitive to family needs." Other comments about the benefits professionally to the trainees include "exceptional reading materials," gained quite a bit of practical knowledge to implement in EI," "heightened awareness of communication skills," "concrete strategies on conflict resolution," "to focus on family strengths and try to listen to what parents want rather than what I think they need." Module Three for each year were the trainees rating their peers as they taught the class on a variety of chosen topics.

Tables 19 and 20 indicated rating results on supervision and peer mentorship, combined for all respondents for year 1998 and 1999 for those who finished all competencies. Rating were distributed in indicators 4 (mildly agree) and 5 (strongly agree) showing very positive ratings for administrative supervision. One hundred percent of the trainees rated their peers in the strongly agree categories in accessibility, feedback, flexibility, communication, support and inspiring confidence.

VI. PROJECT IMPACT

Contribution to current knowledge and practice

This training project has increased current knowledge and practice in the field of early intervention in a number of ways. First, it has developed a forty-one based competency curriculum focusing on family centered principles, interdisciplinary teaming and interagency collaborations. It has incorporated best practices in early intervention theory into topical classroom instruction and developed practicum experiences to carryover content into service delivery. Second, the project developed a training model which contributed to the ongoing process of developing a certificate/credential for early interventionist providing services with Connecticut's Part C system. It also has disseminated materials to other states that have requested assistance with their own efforts in developing credentials in early intervention systems. Third, it has increased the number of early interventionists in Connecticut providing best practice in service delivery in Connecticut's Part C system. Fourth, the project offered a variety of activities consistent with the literature on adult learning, in particular, peer mentorship, thus increasing the effectiveness of training. Fifth, the project developed materials that were used during training and were available for national dissemination. Last, the program evaluated the effects of training across participants thus insuring the systematic refinement of both model components and training activities.

Products

The following products have developed through the course of this project.

Brochure

During the first year of the project an Early Intervention Specialist Brochure was designed, detailing program elements and opportunities for participation. Brochures were disseminated during large scale mailing, at local conferences, early intervention providers and other statewide trainings. A copy of the brochure included in Appendix F.

Student Handbook

A student handbook was designed tracing the history of early intervention and assisting students to accomplish the course work, site participation and program competency tasks for credentialing in early intervention. A copy of the student handbook in included in Appendix F.

Supervision and Mentorship Handbook

This handbook was designed to assist the student in developing adult learning principles when completing the clinical and practicum requirements. It outlines the components of supervisory tasks and peer mentorship relationships. It is located in Appendix F.

Competency Tasks

A list of forty-one competency tasks and criteria was developed to promote effective practices for early interventionists. The criteria included a performance checklist or written reports. A copy of the competencies are located in Appendix D.

Bibliographies

During all three years of the project, the director continually developed, updated and disseminated a bibliography on resources and information concerning the three topic modules on early intervention and best practices. A copy of the bibliographies can be found in Appendix C.

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Table 1

Mean percent of topics per competency rated as a little or not at all knowledgeable (n=142)

	Policies & Procedures	Assessment	Family Centered Care	Teaming	Individualized Program	Service Delivery	Communication/Collaboration	Transitions	Technology
Respondents	47.91	41.25	33.36	26.49	32.38	51.57	43.95	48.95	66.70

Table 2
Frequency of responses to program competency self-assessment (N = 79)

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Program Competencies
1997 - 1999

1 = I have never heard of this competency
2 = I have heard of this competency, but have never observed or experienced it
3 = I have observed this competency, but have not experienced it
4 = I have experience with this competency, but I am not confident in utilizing the information
5 = I have experienced this many times and can apply it, but still feel I could learn more to refine my skills
6 = I have experienced this many times, can apply it, and have refined my skills in this area

Family	NA	1	2	3	4	5	6
1. Implementing a family assessment which includes all of the following: • resources, priorities and concerns • social supports • functions • daily routines • adaptations • coping	1	2	9	11	23	31	2
2. Interviewing a family using: • a planned agenda • effective communication skills • the interview for family outcomes		2	5	11	22	36	3
3. Interviewing a family representing a culturally different heritage		3	11	9	33	19	4
4. Experiencing daily life with a child with disabilities		1	12	23	12	22	9
5. Assessing parent-child interaction including: • implementation • interpretation • intervention objectives	1	1	9	14	23	29	2

Family Con't	**NA**	**1**	**2**	**3**	**4**	**5**	**6**
6. Setting family outcomes including: • Collaborating with team members • Developing and operationalizing objectives	3	1	11	6	15	40	3
7. Reflecting on institutionalization including: • Quality of life indicators • Early intervention reducing the likelihood of institutionalization • Adherence to family centered principles		11	20	15	22	11	
Intervention	**NA**	**1**	**2**	**3**	**4**	**5**	**6**
8. Selecting assessment instruments based on the decision making process	2	5	14	14	14	29	1
9. Administering developmental assessments in all developmental domains including: • Interpreting the psychometric properties • Adapting the assessment • Interpreting the results of the assessment • Communicating the results of the assessment		2	13	14	16	33	1
10. Creating an Individualized Family Service Plan based on the components defined in the federal guidelines	1	1	10	11	17	36	3
11. Implementing the IFSP including all of the following components: • A flexible agenda • Strategies for generalization • Adult learning principles • Data collection		1	13	11	20	29	5
12. Creating intervention programs to include: • Task analysis or instructional sequence • Measurement procedures and criteria for achievement • Baseline and progress data • Instructional routine including presentation, pacing and	1	4	13	16	21	25	

closure • Generalization strategies • Procedures for parents to implement in the daily routine							

Intervention Con't	NA	1	2	3	4	5	6
13. Using effective intervention delivery including: • Adhering to the child's schedule • Social competence • Communication and socialization • Maintaining motivation • Use of incidental teaching and the environment • Integrating skill domains • Data collection		1	9	14	16	37	2
14. Utilizing a variety of teaching and facilitation procedures		1	5	8	16	47	2
15. Incorporating assistive technology into an intervention plan		4	14	13	32	16	
16. Using effective handling, lifting and carrying techniques for an infant/toddler with motor disabilities which includes ensuring the family understands the techniques		2	10	15	22	24	6
17. Using appropriate positioning techniques including: • The rationale for specific positions • The rational for any adaptive equipment • Ensuring the family understands the techniques	1	3	8	17	21	24	5
18. Creating an effective feeding plan which includes: • Proper positioning • Ensuring the family understands the techniques		2	11	17	23	24	2
19. Integrating social competence objectives into the IFSP		2	14	20	18	25	
20. Developing and implementing sleep interventions		16	20	17	18	8	
21. Designing and implementing behavioral interventions	1	1	12	12	19	32	2
22. Describing the etiologies and possible implications of a variety of medical and developmental disabilities, and current intervention techniques and modifications		6	13	11	30	18	1

Intervention Con't	**NA**	**1**	**2**	**3**	**4**	**5**	**6**
23. Describe seizure disorders including effects of medications, intervention during a seizure, and data collection		4	15	22	25	13	
24. Developing a home health care plan for an infant or toddler with medically complex needs		5	24	29	14	7	
Service Model	**NA**	**1**	**2**	**3**	**4**	**5**	**6**
25. Facilitating an IFSP or team meeting		2	12	11	12	37	5
26. Evaluating curriculum guides designed for infants and toddlers including: • Psychometric properties • Coverage or scope • Functional adaptations • Potential as an assessment-to-teaching device • Appropriateness of instructional materials • Utility in an integrated setting	1	9	16	20	21	11	1
27. Consulting to team members, including the family, using adult learning principles and effective communication skills	1	6	18	19	15	19	1
28. Describing the implications of state and federal laws that affect infants and toddlers with disabilities and their families		4	11	17	29	18	
29. Training others in the major functions of his/her discipline and the developmental concepts traditionally covered by that discipline through use of adult learning principles		2	10	9	18	35	5
30. Community mapping on both a regional and family level		14	17	17	16	15	
31. Creating a collaborative partnership with another agency to benefit families		4	13	15	14	31	2
32. Developing a program philosophy regarding delivery of services, child and family development, and transdisciplinary teaming	1	3	14	26	17	16	2

Service Model Con't	NA	1	2	3	4	5	6
33. Creating a plan for service delivery encompassing: • Program philosophy • Orientation for families and staff • Community linkages • Assessment procedures • Curriculum development • Staffing patterns • Staff development • Evaluation of service delivery		5	13	25	19	16	1
*34. Collaborating and mentoring with professionals to enhance practicum skills and develop a self evaluation process	31	3	8	11	16	10	
*35. Transmitting professional knowledge and information on early intervention topics by developing training materials, references and resources in a class format	32	4	11	10	14	8	
36. Advocating for an individual, program or technique, or expansion of services	1	3	10	8	25	28	4
Environment	**NA**	**1**	**2**	**3**	**4**	**5**	**6**
37. Assessing early childhood environments for developmentally appropriate practice and making recommendations for enhancement		1	8	10	19	41	
38. Adapting environments to facilitate development	1	2	7	9	12	47	1
39. Designing and scheduling group environments for infants and toddlers based on: • Space • Duration of interventions • Individual and small group activities • Active participation of all children • Programming integrated functional skill use • Consultation and meetings • Communication with families • Data collection procedures		1	12	13	27	25	1

Environment Con't	NA	1	2	3	4	5	6
40. Observing an infant in the NICU including: • Medical status • Autonomic, motor, state and interactional regulation • Interventions currently implemented • Recommendations for intervention		6	34	10	19	8	2
41. Developing a transition plan as a sending and receiving agency		2	13	10	21	29	4

* Competencies added in 1998; data does not applicable for class year 1997.

Table 3
Description of Self-Assessment Program Competencies by Topic for years 1997-1999 (N = 79)

Topic	Overall Mean	Minimum Mean	Maximum Mean
Family	3.95	1.00	5.13
Intervention	3.83	1.47	5.13
Service Model	3.46	1.17	4.92
Environment	3.52	1.40	5.40
Overall	3.71	1.20	5.00

Table 4
Mean Score of tasks by education for years 1997-1999 (N = 74)

Topic	HS/A.A/RN	Bachelors	Masters/Sixth Year
Family	3.77	3.60	4.30
Intervention	3.43	3.54	4.20
Service Model	2.99	3.25	3.77
Environment	3.20	3.29	3.76
Overall	3.33	3.42	4.05

Table 5
Mean score of tasks by years of experience for years 1997-1999 (N = 77)

Topic	Less than 1 year	1 – 5 years	6 – 10 years	11 – 20 years	21 - highest
Family	3.06	3.85	4.22	4.43	3.05
Intervention	3.03	3.62	4.05	4.41	3.84
Service Model	2.70	3.26	3.79	3.98	2.88
Environment	2.68	3.39	3.64	4.07	4.30
Overall	2.93	3.55	3.91	4.25	3.44

Table 6

Knowledge and experience level of Early Intervention Specialist Program participants (1997 – 1999)

Category	Frequency	Percent
Experience in Early Intervention (N=77)		
Direct Service Provider	62	81.6
Personal experience as a relative	14	18.4
Personal experience having a child with a disability	11	14.5
Been a baby sitter/respite care provider	10	13.2
Other	3	3.9
Knowledge of Early Intervention (N=77)		
Undergraduate degree in special education or related service	41	53.2
Graduate degree in special education or related service	33	42.9
Information acquired through experience	57	74.0
Independent reading or study	49	63.6

Table 7

Frequency of reasons for attending the Early Intervention Specialist Program for years 1997-1999 (N = 77)

Reason	Frequency	Percent of Respondents
To become better informed about early intervention	73	19.3
To better understand, and work towards solutions, for the Birth to Three System	68	17.9
To integrate experience with content	58	15.3
Because of the transdisciplinary focus	39	10.3
To discuss early intervention issues with colleagues	38	10.0
For personal enjoyment and enrichment	33	8.7
To advance in my present job	26	6.9
To learn for the sake of learning	22	5.8
Other – Need CEU's	8	2.1
To be a better parent	7	1.8
Because of the location	4	1.1
To help get a new job	3	.8

Table 8

Frequency of issues most problematic to attending the Early Intervention Specialist Program for years 1997-1999 (N = 70)

Issue	Frequency	Percent of Respondents
Home responsibilities	55	24.1
Job responsibilities	44	19.3
Attending evening classes	43	18.9
Driving distance	38	16.7
Lack of child care	20	8.8
Inflexibility of job schedule	10	4.4
Time commitment	7	3.1
Friends or family attitudes	4	1.8
Transportation difficulties	4	1.8
Return to academic mindset	1	.4
None	1	.4
Disability	1	.4

Figure 1: Description of Participants in Early Intervention Specialist Program by Position

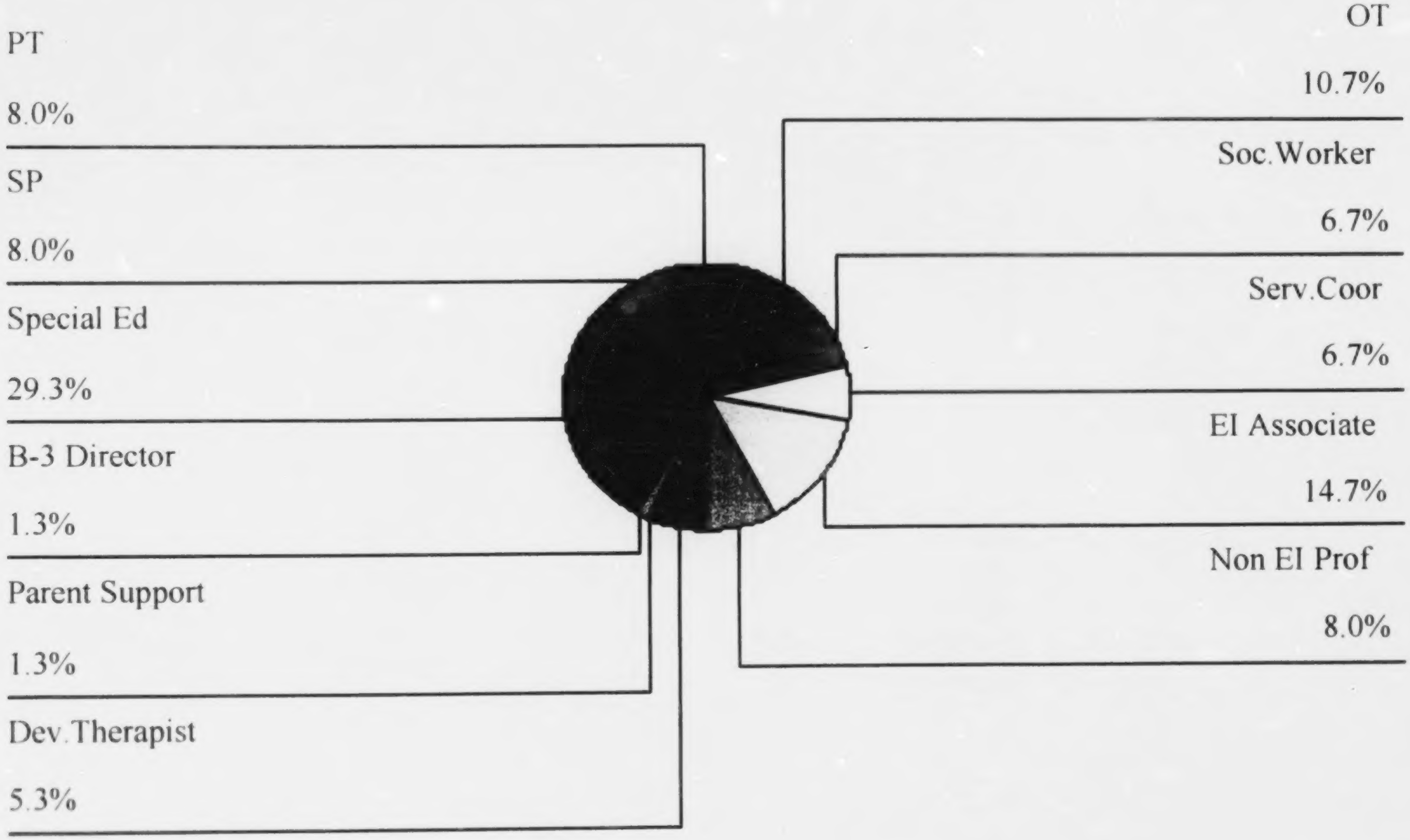

Figure 2: Description of Participants in Early Intervention Specialist Program by Years of Experience

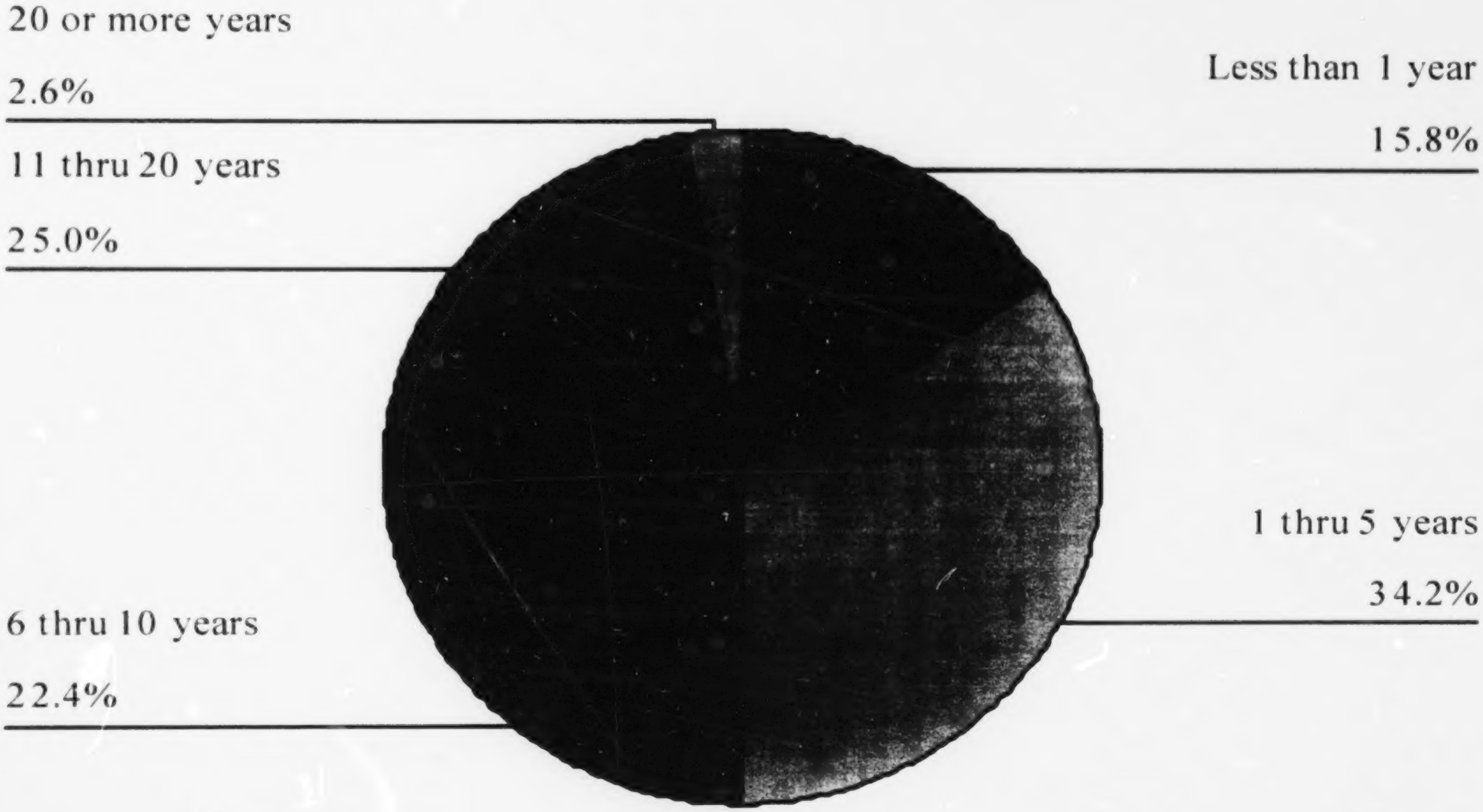

Figure 3: Descriptions of Participants in Early Intervention Specialist Program by Degree

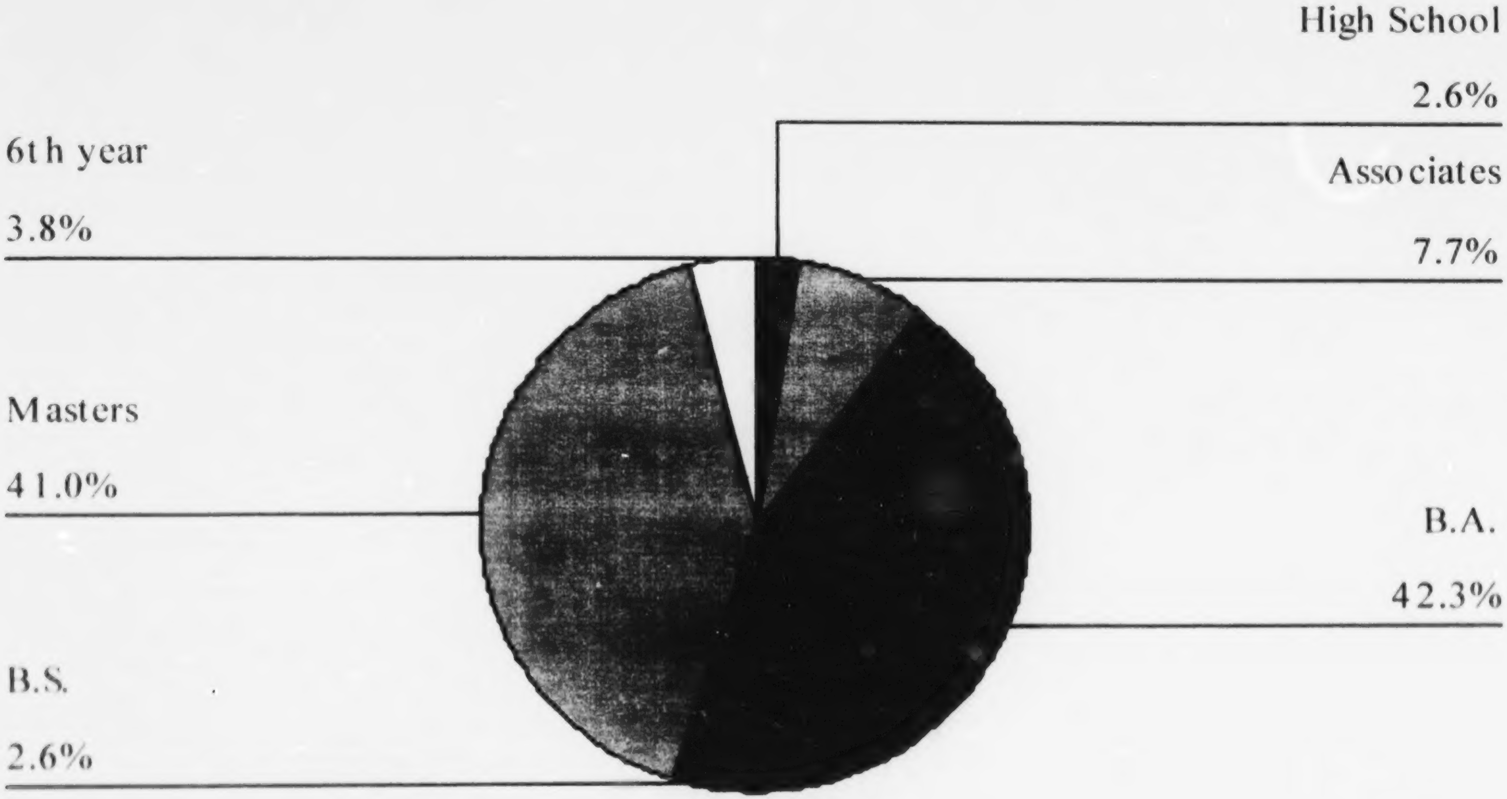

Table 9

Percent of each competency completed for 1997-1999 classes (N=43)

Competency	Percent Completed
Family Assessment	79.1%
Family Interview	88.4%
Cultural Family Interview	74.4%
Child Care	79.1%
Parent-Child Interaction	72.1%
Child Assessment Selection	69.8%
Developmental Assessment	60.5%
Family Outcomes	86.0%
IFSP	83.7%
Facilitating IFSP	76.7%
Family Service Delivery	65.1%
Curriculum Guide	58.1%
Intervention Programs	41.9%
Intervention Delivery	46.5%
Intervention Procedures	41.9%
Assistive Technology	46.5%
Handling, Lifting, Carrying	65.1%
Positioning	58.1%
Feeding	60.5%
Social Competence	32.6%
Sleeping Issues	44.2%
Behavior Issues	37.2%
Environmental Assessment	37.2%
Environmental Adaptations	39.5%
Scheduling	46.5%
NICU	88.4%
Genetic and Medical	62.8%
Seizures and Meds	74.4%
Home Health Care	34.9%
Transition	46.5%
Consultation	39.5%
State and Federal Regulations	65.1%
Community Roles and Knowledge	74.4%
Community Service	51.2%
Collaboration	48.8%

Competency	Percent Completed
Program Philosophy	74.4%
Service Delivery	72.1%
Tour of Southbury	81.4%
Advocacy	58.1%
*Teaching a Class	48.8%
*Mentorship	37.2%

*Competencies added in year 1998; does not include 1997 class data.

Table 10
Pre-test and Post-test means (N=13)

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Program Competencies
1997-1999

1 = I have never heard of this competency
2 = I have heard of this competency, but have never observed or experienced it
3 = I have observed this competency, but have not experienced it
4 = I have experience with this competency, but I am not confident in utilizing the information
5 = I have experienced this many times and can apply it, but still feel I could learn more to refine my skills
6 = I have experienced this many times, can apply it, and have refined my skills in this area

Family	Pre-test mean	Post-test mean
1. Implementing a family assessment which includes all of the following: • resources, priorities and concerns • social supports • functions • daily routines • adaptations • coping	4.54	5.69
2. Interviewing a family using: • a planned agenda • effective communication skills • the interview for family outcomes	4.46	5.77
3. Interviewing a family representing a culturally different heritage	4.00	5.31
4. Experiencing daily life with a child with disabilities	3.85	5.67
5. Assessing parent-child interaction including: • implementation • interpretation • intervention objectives	4.69	5.62

Family Con't	**Pre-test mean**	**Post-test mean**
6. Setting family outcomes including: • Collaborating with team members • Developing and operationalizing objectives	4.58	5.54
7. Reflecting on institutionalization including: • Quality of life indicators • Early intervention reducing the likelihood of institutionalization • Adherence to family centered principles	3.46	5.58
Intervention	**Pre-test mean**	**Post-test mean**
8. Selecting assessment instruments based on the decision making process	4.23	5.23
9. Administering developmental assessments in all developmental domains including: • Interpreting the psychometric properties • Adapting the assessment • Interpreting the results of the assessment • Communicating the results of the assessment	4.00	5.39
10. Creating an Individualized Family Service Plan based on the components defined in the federal guidelines	4.23	5.62
11. Implementing the IFSP including all of the following components: • A flexible agenda • Strategies for generalization • Adult learning principles • Data collection	4.31	5.62
12. Creating intervention programs to include: • Task analysis or instructional sequence • Measurement procedures and criteria for achievement • Baseline and progress data • Instructional routine including presentation, pacing and closure	4.01	5.23

- Generalization strategies - Procedures for parents to implement in the daily routine		

Intervention Con't	Pre-test mean	Post-test mean
13. Using effective intervention delivery including: • Adhering to the child's schedule • Social competence • Communication and socialization • Maintaining motivation • Use of incidental teaching and the environment • Integrating skill domains • Data collection	4.15	5.46
14. Utilizing a variety of teaching and facilitation procedures	4.46	5.54
15. Incorporating assistive technology into an intervention plan	3.85	5.42
16. Using effective handling, lifting and carrying techniques for an infant/toddler with motor disabilities which includes ensuring the family understands the techniques	4.54	5.54
17. Using appropriate positioning techniques including: • The rationale for specific positions • The rational for any adaptive equipment • Ensuring the family understands the techniques	4.31	5.54
18. Creating an effective feeding plan which includes: • Proper positioning • Ensuring the family understands the techniques	4.31	5.62
19. Integrating social competence objectives into the IFSP	4.15	5.23
20. Developing and implementing sleep interventions	3.77	5.46
21. Designing and implementing behavioral interventions	4.39	5.69
22. Describing the etiologies and possible implications of a variety of medical and developmental disabilities, and current intervention techniques and modifications	4.23	5.54

Intervention Con't	Pre-test mean	Post-test mean
23. Describe seizure disorders including effects of medications, intervention during a seizure, and data collection	3.92	5.46
24. Developing a home health care plan for an infant or toddler with medically complex needs	3.39	5.39
Service Model	**Pre-test mean**	**Post-test mean**
25. Facilitating an IFSP or team meeting	4.76	5.77
26. Evaluating curriculum guides designed for infants and toddlers including: • Psychometric properties • Coverage or scope • Functional adaptations • Potential as an assessment-to-teaching device • Appropriateness of instructional materials • Utility in an integrated setting	3.62	5.23
27. Consulting to team members, including the family, using adult learning principles and effective communication skills	4.85	5.85
28. Describing the implications of state and federal laws that affect infants and toddlers with disabilities and their families	3.92	5.54
29. Training others in the major functions of his/her discipline and the developmental concepts traditionally covered by that discipline through use of adult learning principles	3.69	5.54
30. Community mapping on both a regional and family level	4.00	5.54
31. Creating a collaborative partnership with another agency to benefit families	4.15	5.54
32. Developing a program philosophy regarding delivery of services, child and family development, and transdisciplinary teaming	3.77	5.39

Service Model Con't	Pre-test mean	Post-test mean
33. Creating a plan for service delivery encompassing: • Program philosophy • Orientation for families and staff • Community linkages • Assessment procedures • Curriculum development • Staffing patterns • Staff development • Evaluation of service delivery	3.62	5.31
34. Collaborating and mentoring with professionals to enhance practicum skills and develop a self evaluation process	4.00	5.75
35. Transmitting professional knowledge and information on early intervention topics by developing training materials, references and resources in a class format	3.88	5.75
36. Advocating for an individual, program or technique, or expansion of services	4.39	5.46
Environment	**Pre-test mean**	**Post-test mean**
37. Assessing early childhood environments for developmentally appropriate practice and making recommendations for enhancement	4.31	5.77
38. Adapting environments to facilitate development	4.46	5.69
39. Designing and scheduling group environments for infants and toddlers based on: • Space • Duration of interventions • Individual and small group activities • Active participation of all children • Programming integrated functional skill use • Consultation and meetings • Communication with families • Data collection procedures	3.92	5.39

Environment Con't	Pre-test mean	Post-test mean
40. Observing an infant in the NICU including: • Medical status • Autonomic, motor, state and interactional regulation • Interventions currently implemented • Recommendations for intervention	3.00	5.39
41. Developing a transition plan as a sending and receiving agency	4.46	5.69

EARLY INTERVENTION SPECIALIST PROGRAM
OBSERVATION/CONFERENCE CONTACT LOG
1998 CLASS

Table 11

US = UNIVERSITY SUPERVISOR PS = PROVIDER SUPERVISOR PM = PEER MENTOR

NAME /ID	# of Observations				# of Observation Hours				# of Conference Contacts				# of Conference Contact Hours				# of Completed Competencies
	US	PS	PM	**Total**	US	PS	PM	**Total**	US	PS	PM	**Total**	US	PS	PM	**Total**	
101	4	2	3	**9**	7	2	3	**12**	13	4	11	**28**	20	4	8	**32**	33
102	2	12	36	**50**	4	13	35	**57**	20	59	31	**110**	15	30	27	**62**	22
103	0	1		**1**	0	1		**1**	19		30	**49**	17		54	**71**	22
104	0	-	0	**0**	0	-	0	**0**	3	-	3	**6**	3	-	10	**13**	15
105	4	0	4	**4**	7	0	0	**7**	45	0	22	**67**	33		15	**48**	21
106	5	2	4	**11**	15	4	4	**23**	8	1	5	**14**	18	1	15	**34**	18
116	7	0	12	**19**	12	0	-	**12**	22	6	14	**45**	26	6.5	73	**105.5**	42
107	3	2	5	**10**	11	2	0	**11**	19	2	17	**36**	31	2	47	**79**	31
108	0	-	-	**0**	0	-	-	**0**	58	0	4	**62**	24	6.5	15	**45.5**	14
110	0	6	-	**6**	6	-	-	**6**	15	3	10	**28**	23	3	28	**54**	18
113	3	0	-	**3**	2	0	-	**6**	7	0	3	**10**	10	0	15	**25**	8
123	1	-	0	**1**	3	-	0	**3**	3	-	3	**6**	3	-	9	**12**	11

EARLY INTERVENTION SPECIALIST PROGRAM
OBSERVATION/CONFERENCE CONTACT LOG
1999 CLASS

Table 12

US = UNIVERSITY SUPERVISOR PM = PEER MENTOR* (Mentorship hours were kept on separate forms and included in Portfolios)

NAME /ID	# of Observations				# of Observation Hours				# of Conference/Workshop Contacts				# of Conference Contact Hours				# of Completed Compet-encies
	US	PM	Cancel	**Total**	US	PM	Cancel	**Total**	US	PM	Cancel	**Total**	US	PM	Total		
151	4		2	**4**	6			**6**	8			**8**	28		**28**		**42**
153	3		0	**3**	3			**8**	6			**6**	22		**22**		**42**
155	3		0	**3**	2			**2**	7			**7**	21.5		**21.5**		**18**
156	2		0	**3**	2			**3**	10			**10**	27.5		**27.5**		**42**
159	3		0	**3**	3			**3**	7			**7**	22		**22**		**42**
160	6		0	**6**	5			**5**	8			**8**	22.5		**22.5**		**23**
161	2		4	**2**	2			**2**	9			**9**	23		**23**		**17**
178	4		0	**4**	4			**4**	8			**8**	24.5		**24.5**		**19**
166	4		0	**4**	6			**6**	10			**10**	26		**26**		**42**
172	4		0	**4**	5			**5**	8			**8**	29		**29**		**42**
173	7		0	**7**	12			**12**	9			**9**	33		**33**		**42**

Table 13

Satisfaction with All Topics
(N=877)

All Topics Overall – 1997 - 1999

	Percent Responding					**Summary Statistics**	
Statement	Strongly Disagree 1	Mildly Disagree 2	Neutral 3	Mildly Agree 4	Strongly Agree 5	Mean	Standard Deviation
The presentation was well organized	.1	.5	5.2	35.6	58.6	4.52	.63
The speaker(s) was knowledgeable about the subject	.3	.1	1.0	17.6	81.0	4.79	.49
The reading materials were informative and relevant to the subject	.4		5.2	31.9	62.5	4.56	.63
There were opportunities provided for questions and discussions	.1	.9	2.6	22.2	74.1	4.69	.59
A variety of methods and techniques were used		.8	8.0	41.7	49.5	4.40	.67
The information is useful to my job	.3	.1	2.4	23.7	73.5	4.70	.55
Small group activities allowed for problem solving	.9	1.8	9.0	28.4	59.8	4.45	.80
Overall rating of the individual topic	.1	.2	2.7	30.3	66.6	4.63	.56

Table 14

Satisfaction with Sessions – Overall by Topic
(N = 877)

	Percent Responding					Summary Statistics	
Statement	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
Family Systems Theory			4.0	16.0	80.0	4.76	.52
The Role of Social Support			1.6	30.6	67.7	4.66	.51
Family Assessment		1.4	4.1	36.5	58.1	4.51	.65
Implementing the IFSP				20.7	79.3	4.79	.41
Evaluation Models				24.0	16.0	4.76	.44
Types of Teams				16.7	83.3	7.83	.41
Team Process and Problem Solving				50.0	50.0	4.50	.53
Assessment, Intervention, Evaluation				50.0	50.0	4.50	.55
NICU Cognition Communication				50.0	50.0	4.50	.55
Assessment Protocols Across Disciplines			17.4	39.1	43.5	4.26	.75
Intervention Protocols Across Disciplines			4.4	28.9	66.7	4.62	.58
Evaluation Protocols Across Disciplines			6.3	68.8	25.0	4.19	.54
Types of Teams & Process and Problem Solving			5.9	17.6	16.5	4.71	.59
Assessment, Intervention, Evaluation & NICU Cognition Communication			6.7	20.0	73.3	4.67	.62

	Percent Responding					Summary Statistics	
Statement	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
Motor/Adaptive/Self Help & Assess Protocols Across Disciplines				33.3	66.7	4.67	.48
Intervention Protocols Across Disciplines & Evaluation Protocols Across Disciplines				21.1	78.9	4.79	.42
Philosophy				42.9	57.1	4.57	.51
Service Parameters and Coordination				42.9	57.1	4.57	.51
Interagency Issues, Collaboration & Negotiation				60.0	40.0	4.40	.55
Community Mapping and Financing			5.9	47.1	47.1	4.41	.62
IFSP Revisited				60.0	40.0	4.40	.55
Transition				83.3	16.7	4.17	.41
Medical Issues and Ethics					100.0	5.00	.00
Philosophy, Collaboration and Medical Issues				27.3	72.7	4.73	.47
Transitions				11.1	88.9	4.89	.33
IFSP and Advocacy/Systems Change				50.0	50.0	4.50	.52
Ethics			3.2	29.0	67.7	4.65	.55
Resiliency		2.7	5.4	40.5	51.4	4.38	.83
Natural Environment/NICU				54.5	45.5	4.45	.52
Team Content/Cognition Communication				30.4	69.6	4.70	.47
Team Process and Communication				7.1	92.9	4.93	.27
Team Maintenance and Evaluation				14.3	85.7	4.86	.36

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	Percent Responding					Summary Statistics	
Statement	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
Evaluation and Assessment Protocols				15.4	84.6	4.85	.38
Social Competence/Communication			4.2	29.2	66.7	4.63	.58
Evaluation and Instructional Plans				70.0	30.0	4.30	.48
Vision Statement				8.3	91.7	4.92	.29
Education of Young Children w/Autism				20.0	80.0	4.80	.42
Empowering Families				10.0	90.0	4.90	.32
Collaborative Approaches			10.0	50.0	40.0	4.30	.67
Transition Preparation from 0 – 3					100.0	5.00	.00
Role of Service Coordinator				22.2	77.8	4.78	.44
Developing Outcomes through Collaboration Within Natural Environments				42.9	57.1	4.57	.53
Collaboration				16.7	83.3	4.67	.82
Families with Special Needs		5.0	10.0	50.0	35.0	4.15	.81
Team Content: Motor Issues				29.6	70.4	4.70	.47
Family Resource Centers				11.1	88.9	4.89	.32
Medical Home					100.0	5.00	.00

Table 15
Frequency of responses to consumer satisfaction with Module 1
(N=32)

Module Satisfaction
1997 - 1999

	Percent Responding					Summary Statistics	
The Faculty:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. were prepared				6.3	93.8	4.94	.25
2. were organized			3.1	15.6	81.3	4.78	.49
3. stated clear objectives			6.3	25.0	68.8	4.63	.61
4. were knowledgeable				6.3	93.8	4.94	.25
5. were enthusiastic				15.6	84.4	4.84	.37
6. stimulated interest				31.3	68.8	4.69	.47
7. were easy to listen to				28.1	71.9	4.72	.46
8. were articulate/spoke clearly				6.3	93.8	4.94	.25
9. used a variety of activities that corresponded with content			3.1	21.9	75.0	4.72	.52
The Faculty:	**Strongly**	**Mildly**	**Neutral**	**Mildly**	**Strongly**	**Mean**	**Standard**

	Disagree	Disagree		Agree	Agree		Deviation
10. maintained a challenging but comfortable pace for learning			15.6	50.0	34.4	4.19	.69
11. allowed enough time for questions			6.3	50.0	43.8	4.38	.61
12. sufficiently answered questions			3.1	34.4	62.5	4.59	.56
13. valued my input		3.1	6.3	9.4	81.3	4.69	.74
14. respected the experience and perceptions of participants			3.1	15.6	81.3	4.78	.49
15. had an agenda, objectives and resources				15.6	84.4	4.84	.37
16. kept on task				31.3	68.8	4.69	.47
17. were available to participants for feedback and discussion			3.1	37.5	59.4	4.56	.56
Content:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. objectives of the module were met				21.9	78.1	4.78	.42
2. all topics in the syllabus were addressed				12.5	87.5	4.88	.34
3. the materials (e.g., readings, overheads) were relevant to the class content			3.1	25.0	71.9	4.69	.54
Content:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**

4. adequate illustrations and examples were used during presentations				40.6	59.4	4.60	.50
5. time was well organized			9.4	40.6	50.0	4.41	.67
6. the information is relevant and can be applied to my work situation				18.8	81.3	4.81	.40
7. I feel I now have a better understanding of the subject present				15.6	84.4	4.84	.37

Table 16
Frequency of responses to consumer satisfaction with Module 2
(N=24)

Module Satisfaction
1997 - 1999

	Percent Responding					**Summary Statistics**	
The Faculty:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. were prepared			4.2	20.8	75.0	4.71	.55
2. were organized			8.3	29.2	62.5	4.54	.66
3. stated clear objectives			4.2	25.0	70.8	4.63	.71
4. were knowledgeable				4.0	96.0	4.96	.20
5. were enthusiastic			4.2	16.7	79.2	4.75	.53
6. stimulated interest			4.2	37.5	58.3	4.54	.59
7. were easy to listen to				37.5	62.5	4.63	.50
8. were articulate/spoke clearly				16.0	84.0	4.84	.37
9. used a variety of activities that corresponded with content				37.5	62.5	4.63	.50
The Faculty:	**Strongly**	**Mildly**	**Neutral**	**Mildly**	**Strongly**	**Mean**	**Standard**

	Disagree	Disagree		Agree	Agree		Deviation
10. maintained a challenging but comfortable pace for learning		12.0	16.0	24.0	48.0	4.08	1.07
11. allowed enough time for questions			16.0	36.0	48.0	4.32	.75
12. sufficiently answered questions			8.0	36.0	56.0	4.48	.65
13. valued my input		8.0	8.0	20.0	64.0	4.40	.96
14. respected the experience and perceptions of participants		4.0	16.0	20.0	60.0	4.36	.91
15. had an agenda, objectives and resources			4.0	28.0	38.0	4.64	.57
16. kept on task			12.0	32.0	56.0	4.44	.71
17. were available to participants for feedback and discussion			16.0	24.0	60.0	4.44	.77

Content:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. objectives of the module were met				36.0	64.0	4.64	.49
2. all topics in the syllabus were addressed				32.0	68.0	4.68	.48
3. the materials (e.g., readings, overheads) were relevant to the class content			4.0	36.0	60.0	4.56	.58
Content:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**

4. adequate illustrations and examples were used during presentations			4.0	40.0	56.0	4.52	.59
5. time was well organized		8.0	24.0	28.0	40.0	4.00	1.00
6. the information is relevant and can be applied to my work situation				24.0	76.0	4.76	.44
7. I feel I now have a better understanding of the subject present				32.0	68.0	4.68	.48

Table 17
Frequency of responses to consumer satisfaction with Module 3
(N=20)

Module Satisfaction
1997 - 1999

The Faculty:	Percent Responding Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Summary Statistics Mean	Standard Deviation
1. were prepared			5.0	25.0	70.0	4.65	.59
2. were organized			10.0	30.0	60.0	4.50	.69
3. stated clear objectives			15.0	20.0	65.0	4.50	.76
4. were knowledgeable			5.0	20.0	75.0	4.70	.57
5. were enthusiastic			10.0	20.0	70.0	4.60	.68
6. stimulated interest			5.0	30.0	65.0	4.60	.60
7. were easy to listen to			5.0	20.0	75.0	4.70	.57
8. were articulate/spoke clearly			5.0	5.0	90.0	4.85	.50
9. used a variety of activities that corresponded with content			5.0	30.0	65.0	4.60	.60

The Faculty:	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
10. maintained a challenging but comfortable pace for learning			10.0	30.0	60.0	4.50	.69
11. allowed enough time for questions			10.0	15.0	75.0	4.65	.67
12. sufficiently answered questions			10.0	10.0	80.0	4.70	.66
13. valued my input		5.0	15.0	30.0	50.0	4.25	.91
14. respected the experience and perceptions of participants		5.0	10.0	20.0	65.0	4.45	.89
15. had an agenda, objectives and resources			5.0	10.0	85.0	4.80	.52
16. kept on task			10.0	35.0	55.0	4.45	.69
17. were available to participants for feedback and discussion			10.0	15.0	75.0	4.65	.67

Content:	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
1. objectives of the module were met			10.5	21.1	68.4	4.58	.69
2. all topics in the syllabus were addressed			5.0	25.0	70.0	4.65	.59
3. the materials (e.g., readings, overheads) were relevant to the class content		5.0	10.0	35.0	50.0	4.30	.87
Content:	**Strongly**	**Mildly**	**Neutral**	**Mildly**	**Strongly**	**Mean**	**Standard**

	Disagree	Disagree		Agree	Agree		Deviation
4. adequate illustrations and examples were used during presentations			15.0	15.0	70.0	4.55	.76
5. time was well organized		5.0	20.0	30.0	45.0	4.15	.93
6. the information is relevant and can be applied to my work situation			20.0	5.0	75.0	4.55	.83
7. I feel I now have a better understanding of the subject present			15.0	20.0	65.0	4.50	.76

Table 18
Frequency of responses to consumer satisfaction with All Modules
(N=96)

Module Satisfaction
1997 - 1999

	Percent Responding					Summary Statistics	
The Faculty:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. were prepared			3.2	21.1	75.8	4.73	.52
2. were organized		1.1	6.3	29.5	63.2	4.55	.67
3. stated clear objectives		3.2	10.5	24.2	62.1	4.45	.81
4. were knowledgeable			1.0	13.5	85.4	4.84	.39
5. were enthusiastic			3.2	16.8	80.0	4.77	.49
6. stimulated interest			2.1	31.6	66.3	4.64	.52
7. were easy to listen to			2.1	30.5	67.4	4.65	.52
8. were articulate/spoke clearly			2.1	10.4	87.5	4.85	.41
9. used a variety of activities that corresponded with content			2.1	25.3	72.6	4.71	.50
The Faculty:	**Strongly**	**Mildly**	**Neutral**	**Mildly**	**Strongly**	**Mean**	**Standard**

	Disagree	Disagree		Agree	Agree		Deviation
10. maintained a challenging but comfortable pace for learning		3.1	12.5	33.3	51.0	4.32	.81
11. allowed enough time for questions			8.3	33.3	58.3	4.50	.65
12. sufficiently answered questions			6.3	26.0	67.7	4.62	.61
13. valued my input		4.2	7.3	16.7	71.9	4.56	.81
14. respected the experience and perceptions of participants		2.1	7.3	20.8	69.8	4.58	.72
15. had an agenda, objectives and resources		1.0	2.1	19.8	77.1	4.73	.55
16. kept on task			6.3	32.3	61.5	4.55	.61
17. were available to participants for feedback and discussion			8.3	22.9	68.8	4.60	.64
Content:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. objectives of the module were met			3.2	26.3	70.5	4.67	.54
2. all topics in the syllabus were addressed		1.0	2.1	20.8	76.0	4.72	.56
3. the materials (e.g., readings, overheads) were relevant to the class content		1.1	4.2	26.3	68.4		
Content:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**

4. adequate illustrations and examples were used during presentations			4.2	30.2	65.6	4.62	.57
5. time was well organized		3.1	14.6	35.4	46.9	4.26	.82
6. the information is relevant and can be applied to my work situation			4.2	17.7	78.1	4.74	.53
7. I feel I now have a better understanding of the subject present			3.1	20.8	76.0	4.73	.51

Table 19
Frequency of responses to consumer satisfaction with Peer Mentorship (N=13)

1998 - 1999 Class

	Percent Responding					Summary Statistics	
My Peer Mentor:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. was accessible for feedback					100.0	5.00	.00
2. communicated feedback					100.0	5.00	.00
3. was flexible					100.0	5.00	.00
4. provided qualitative feedback					100.0	5.00	.00
5. provided relevant feedback					100.0	5.00	.00
6. was supportive					100.0	5.00	.00
7. inspired my confidence					100.0	5.00	.00

Mentorship Experience - I had an:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. opportunity to complete competencies on the job			7.7	23.1	69.2	4.62	.65

Supervisor Experience – I had a(n):	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
2 opportunity to learn more about:							
a normal development			8.3	16.7	75.0	4.67	.65
b impact of NICU on families				8.3	91.7	4.83	.58
c developmental intervention				8.3	91.7	4.92	.29
d teaching procedures			8.3	8.3	83.3	4.75	.62
e orchestrating a classroom			16.7	41.7	41.7	4.25	.75
f integrating therapy				33.3	66.7	4.67	.49
g interacting with families				8.3	91.7	4.92	.29
h collaboration				8.3	91.7	4.92	.29
i team development					100.0	5.00	.00
j staffing development			8.3	8.3	83.3	4.67	.89
3 useful experience for my professional development					100.0	5.00	.00

Competencies:	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
1 were related to module content			25.0	25.0	50.0	4.25	.87
2 were relevant to my job situation			8.3	50.0	41.7	4.33	.65

Competencies:	Strongly	Mildly	Neutral	Mildly	Strongly	Mean	Standard

	Disagree	Disagree		Agree	Agree		Deviation
3. were individualized to meet my needs			33.3	33.3	33.3	4.00	.85
4. were completed with adequate support			8.3	41.7	50.0	4.42	.67
5. enabled me to perform better at my job			8.3	33.3	58.3	4.50	.67
6. had well defined criteria			25.0	41.7	33.3	4.08	.79

Table 20
Frequency of responses to consumer satisfaction with Supervision Module
(N=12)

1998 – 1999 Classes

	Percent Responding					Summary Statistics	
My Supervisor:	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. was accessible for feedback				16.7	83.3	4.83	.39
2. communicated feedback			8.3	8.3	83.3	4.75	.62
3. was flexible				16.7	83.3	4.83	.39
4. provided qualitative feedback				16.7	83.3	4.83	.39
5. provided relevant feedback				16.7	83.3	4.83	.39
6. was su[illegible]tive				8.3	91.7	4.92	.29
7. inspired my confidence				8.3	91.7	4.92	.29
Supervisor Experience - I had a(n):	**Strongly Disagree**	**Mildly Disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Mean**	**Standard Deviation**
1. opportunity to complete competencies on the job			16.7	25.0	58.3	4.42	.79

Mentorship Experience – I had an:	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Mean	Standard Deviation
2. opportunity to learn more about:							
a. normal development			7.7	23.1	69.2	4.62	.65
b. impact of NICU on families			7.7	30.8	61.5	4.54	.66
c. developmental intervention				23.1	76.9	4.77	.44
d. teaching procedures				23.1	76.9	4.77	.44
e. orchestrating a classroom			7.7	38.5	53.8	4.46	.66
f. integrating therapy			7.7	7.7	84.6	4.77	.60
g. interacting with families				23.1	76.9	4.77	.44
h. home visits				15.4	84.6	4.85	.38
i. team development					100.0	5.00	.00
j. staffing development				7.7	92.3	4.92	.28
3. overall effective mentorship experience				7.7	92.3	4.92	.28

APPENDIX A

STATEWIDE NEEDS ASSESSMENT
PARTICIPANT SELF ASSESSMENT

UCONN HEALTH CENTER
DIVISION OF CHILD AND FAMILY STUDIES
BIRTH TO THREE COMPREHENSIVE SYSTEM OF PERSONNEL DEVELOPMENT
Dowling North, MC 6222
263 Farmington Ave.
Farmington, CT 06030
(860) 679-4632

EARLY INTERVENTION PROGRAM ADMINISTRATOR'S NEEDS ASSESSMENT

To be filled out by program administrators only:

Name: ______________________________

Agency: ______________________________ Phone: ____________________

PROGRAM DESCRIPTION

1. What type of service environment is your agency? (Check **one**)

_____ Public education program (including RESCs, school systems)

_____ Private non-profit program (non-government agencies)

_____ Private for-profit program (independently owned agencies)

_____ Public service program (government agencies other than education)
Please list which agency: ____________________

_____ Hospital/clinic setting

_____ Mental health facility, agency, or program

_____ Other: ______________________________

2. What statement best describes your responsibility as a program administrator?

_____ I am fully responsible for decision making for the Birth to Three Program within a larger organization.

_____ I am responsible for the Birth to Three Program within a larger organization and final decision making is made in conjunction with my supervisor program director.

_____ I am responsible for the entire agency/program that works solely with infants and toddlers with disabilities and their families as a Birth to Three Provider.

_____ I am responsible for the entire agency/program including programs other than Birth to Three.

ADMINISTRATIVE DEVELOPMENT NEEDS

3. Please rate how much you know about the following :

a. Integrating the Birth to Three Mission Statement into my program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ________________________________

b. Strategic planning for my program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ________________________________

c. Financial management and forecasting for my program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ________________________________

d. The effects of Birth to Three policy on my organization

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ________________________________

e. The effects of other influences on my organization

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ________________________________

f. Current policy implications on:

1. a system level **Low** 1 2 3 4 5 **High**
2. a state level **Low** 1 2 3 4 5 **High**
3. a national level **Low** 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ________________________________

3. con't. Please rate how much you know about the following:

g. Being a change agent within my organization

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

h. Building relationships with Birth to Three lead agency administration

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

i. Using Birth to Three lead agency administration appropriately

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

j. Entering into interagency agreements with other agencies to provide comprehensive services

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

k. Networking with other early intervention agencies

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

l. Networking with other community agencies including hospitals, DCF, childcare, etc

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

m. Working with higher administration within my own organization

Low 1 2 3 4 5 **High** **NA**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____________________

3. con't. Please rate how much you know about the following:

n. Administering Birth to Three policy and procedures

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

o. Administering my agency's policy and procedures

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

p. Incorporating leadership skills into my role as an administrator

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

q. Implementing concepts of organization theory within my program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

r. Generating and implementing creative ideas for service delivery in my program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

s. Utilizing motivation theory (intrinsic vs. extrinsic factors) for my staff

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

t. Supervising staff

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

3. con't. Please rate how much you know about the following:

u. Mediating employee conflicts

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

v. Mediating family and provider conflicts

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

w. Building teams within my organization

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

x. Organizing staff development for my Birth to Three staff

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

y. Providing staff development for my Birth to Three staff

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

z. Evaluating the efficacy of my program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

aa. Performing staff evaluations

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ______________________________

3. con't. Please rate how much you know about the following:

bb. Performing a program evaluation on all aspects of Birth to Three program

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

cc. Accessing third party reimbursement

Low 1 2 3 4 5 **High**

Are you or your agency able to do this? ______ Yes ______ No

If no, why not? ____

4. Are there other areas of administrative development not listed in question #3 you would like to enhance through professional development? ____

(continued on next page)

5. What experiences do you feel have prepared you for your role as an administrator in Birth to Three?

______ Courses (please list): ______

______ Inservices (please list): ______

______ Articles/books (please list): ______

______ Lectures/speakers (please list): ______

______ Consultants (please list): ______

______ On the job experiences (please list): ______

______ Other (please list): ______

______ No preparation

STAFF TRAINING NEEDS

6. Please circle **your opinion** of **your staff's** need for more training in the following topics related specifically to children ages birth to three with disabilities and their families:

ASSESSMENT	Definite Need	Some Need	No Need
a. Conducting developmental assessments on children			
Birth to 6 months	1	2	3
6 to 12 months	1	2	3
12 to 18 months	1	2	3
18 to 36 months	1	2	3
b. Understanding and assessing family priorities, resources and concerns	1	2	3
c. Selecting appropriate assessment instruments or procedures	1	2	3
d. Collaborating with families in the assessment process	1	2	3
e. Implementing various assessment procedures	1	2	3
f. Assessing play skills	1	2	3
g. Assessing the parent-child relationship	1	2	3
h. Assessing environments	1	2	3
i. Participating in transdisciplinary assessments	1	2	3
j. Communicating assessment results to families	1	2	3
k. Writing integrated assessment reports	1	2	3

(continued on next page)

SERVICE DELIVERY

	Definite Need	Some Need	No Need
a. Using assessment results to develop the IFSP	1	2	3
b. Developing objectives to support the family 's IFSP outcomes	1	2	3
c. Developing appropriate interventions for infants and toddlers with disabilities who are:			
Birth to 6 months	1	2	3
6 to 12 months	1	2	3
12 to 18 months	1	2	3
18 to 36 months	1	2	3
d. Working with families to achieve family outcomes	1	2	3
e. Adapting environments, materials and activities for infants and toddlers with disabilities	1	2	3
f. Developing interventions to be implemented in natural environments	1	2	3
g. Developing interventions to be implemented within family's routines	1	2	3
h. Developing strategies to achieve family outcomes on the IFSP	1	2	3
i. Evaluating the impact of service delivery on the child and family	1	2	3
j. Collaborating with professionals from other disciplines to provide high quality, appropriate services	1	2	3
k. Providing services for infants and toddlers with medically complex needs	1	2	3
l. Providing services for infants and toddlers with autism/PDD	1	2	3
m. Providing services for infants and toddlers with sensory impairments	1	2	3
n. Using community resources to meet IFSP outcomes	1	2	3
o. Collecting data and analyzing progress	1	2	3
p. Using assistive technology and services	1	2	3

FAMILY CENTERED CARE

	Definite Need	Some Need	No Need
a. Collaborating with families to develop Individualized Family Service Plans (IFSPs)	1	2	3
b. Assisting families to understand their child's developmental/health status	1	2	3
c. Providing service coordination	1	2	3
d. Being responsive to cultural/language diversity	1	2	3
e. Consulting with families and other caregivers (child care centers, baby-sitters) to implement interventions in natural routines	1	2	3
f. Communicating the benefits of the transdisciplinary approach to families	1	2	3
g. Working with families and their receiving programs to develop transition plans	1	2	3
h. Working with families from different cultures and communities	1	2	3

TEAMING

	Definite Need	Some Need	No Need
a. Facilitating team meetings	1	2	3
b. Facilitating team assessments	1	2	3
c. Facilitating team intervention	1	2	3
d. Learning from other team members	1	2	3
e. Negotiating between diverse teams members	1	2	3
f. Collaborating with community programs and services	1	2	3
g. Collaborating with LEAs during transition	1	2	3

DEVELOPMENTAL KNOWLEDGE

	Definite Need	Some Need	No Need
a. Understanding the range and variability of typical infant and toddler development	1	2	3
b. Understanding the range and variability of atypical infant and toddler development	1	2	3
c. Understanding the implication of different developmental and medical diagnoses for the development of infants and toddlers	1	2	3
d. Integrating developmental domains for a holistic picture of child	1	2	3
e. Understanding the impact of parent-child relationship on development	1	2	3

PROGRAM ISSUES

	Definite Need	Some Need	No Need
a. Understanding insurance/billing procedures	1	2	3
b. Supervising other staff	1	2	3
c. Using community resources for the IFSP	1	2	3
d. Working with other agencies in your community	1	2	3
e. Working with the medical community	1	2	3
f. Working with the LICC	1	2	3
g. Ensuring confidentiality and family privacy	1	2	3

POLICIES/PROCEDURES

	Definite Need	Some Need	No Need
a. Understanding state and federal regulations guiding early intervention	1	2	3
b. Explaining to families the law and their rights	1	2	3
c. Understanding procedural safeguards	1	2	3

7. Are there any other training topics that need to be addressed? ______________________

____

____

____

____

____

8a. Does your agency provide:

______ Inservice training for staff

______ Placements for other professional disciplines

______ Placements for student teachers

______ None of above

8b. If inservice training, specify type: ______________________

____

____

____

____

8c. If placements, specify academic institutions: ______________________

From which disciplines? ______________________

9. Does your agency require formal staff development?

______ Yes

______ No

10. If yes, does your agency currently provide:

______ Release or compensatory time

______ Reimbursement for the cost of attendance

11. If your agency does not currently provide the incentives in question 10, would you be willing to provide in the future :

______ Release or compensatory time

______ Reimbursement for the cost of attendance

______ I do not have the authority to make that decision

RECRUITMENT AND RETENTION ISSUES

12. For each of the positions listed, please indicate the Full Time Equivalent (FTE) of your current staff and the number of vacancies providing direct service to children from birth to three years with disabilities. This includes consultants/contractors. Please also rate the difficulty in recruiting and retaining new staff by circling the appropriate number. If a listed position is not part of your early intervention staff, write N/A in the column showing current # of FTE.

This information will be used for the Birth to Three report to OSEP. Please take every effort to be as accurate as possible.

Position	Current # of FTE Employed	Current # of FTE Vacancies	Recruitment Difficulty Easy				Impossible	Retention Difficulty Easy				Impossible
Audiologist			1	2	3	4	5	1	2	3	4	5
Family Therapist			1	2	3	4	5	1	2	3	4	5
Nurse			1	2	3	4	5	1	2	3	4	5
Nutritionist			1	2	3	4	5	1	2	3	4	5
Occupational Therapist			1	2	3	4	5	1	2	3	4	5
Orientation and Mobility Specialist			1	2	3	4	5	1	2	3	4	5
Pediatrician			1	2	3	4	5	1	2	3	4	5
Physical Therapist			1	2	3	4	5	1	2	3	4	5
Physician (other than Pediatrician)			1	2	3	4	5	1	2	3	4	5
Psychologist			1	2	3	4	5	1	2	3	4	5
Social Worker			1	2	3	4	5	1	2	3	4	5
Speech Language Pathologist			1	2	3	4	5	1	2	3	4	5
Teacher of the Blind			1	2	3	4	5	1	2	3	4	5
Teacher of the Deaf and Hearing Impaired			1	2	3	4	5	1	2	3	4	5
Teacher - Special Education			1	2	3	4	5	1	2	3	4	5
Paraprofessional (please specify):												
			1	2	3	4	5	1	2	3	4	5
			1	2	3	4	5	1	2	3	4	5
Other (please specify):												
			1	2	3	4	5	1	2	3	4	5
			1	2	3	4	5	1	2	3	4	5

(Continued on next page)

13. When you encounter difficulties in staffing positions in your agency, what are your perceptions of the major reasons for that difficulty? (Check all that apply)

______ Professionals not available in sufficient numbers

______ Professionals not appropriately trained to work with infants and toddlers

______ Bilingual professionals not available in sufficient number

______ Professionals who sign are not available in sufficient number

______ Full-time/part-time status of positions available not compatible with needs of potential employees

______ Professionals from diverse cultures not available

______ Agency salary scale and benefits are not competitive

______ Location of program

______ Location of home visits

______ Insufficient funding for salaries

______ Professionals prefer part-time consulting to staff positions

______ Not applicable

______ Other (Please comment) ____
____
____
____
____

14. Do you find it difficult to hire professionals whose cultural and/or language backgrounds are similar to the children you serve?

______ Yes ______ No

15. If yes, for which cultural/language groups? (check all that apply). Be specific:

______ African-American ____________________

______ Asian ____________________

______ Hispanic/Latino ____________________

______ Other (please specify) ____________________

______ Portuguese

______ Polish

______ Sign language

(continued next page)

16. Which bilingual (including sign language) professionals do you have difficulty hiring as staff or consultants? (Please list whether sign language or specify language/culture)

_____ Teachers : _______________

_____ Psychologists: _______________

_____ Occupational Therapists : _______________

_____ Physical Therapists : _______________

_____ Speech Pathologists: _______________

_____ Social Workers : _______________

_____ Other (please specify) _______________

_____ Not applicable

OTHER

17. What other issues/factors do feel are important for the ICC to know from Birth to Three program administrators? _______________

____

____

____

____

THANK YOU!

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Program Competencies
Self Assessment

Name: ______________________________

Please rate the below competencies based on the following statements:

1 = I have never heard of this competency
2 = I have heard of this competency, but have never observed or experienced it
3 = I have observed this competency, but have not experienced it
4 = I have experience with this competency, but I am not confident in utilizing the information
5 = I have experienced this many times and can apply it, but still feel I could learn more to refine my skills
6 = I have experienced this many times, can apply it, and have refined my skills in this area

Family

1.	Implementing a family assessment which includes all of the following: * resources, priorities and concerns * social supports * functions * daily routines * adaptation * coping	1	2	3	4	5	6
2.	Interviewing a family using: * a planned agenda * effective communication skills * the interview for family outcomes	1	2	3	4	5	6
3.	Interviewing a family representing a culturally different heritage	1	2	3	4	5	6
4.	Experiencing daily life with a child with disabilities	1	2	3	4	5	6
5.	Assessing parent-child interaction including: * implementation * interpretation * intervention objectives	1	2	3	4	5	6
6.	Setting family outcomes including: * collaborating with team members * developing and operationalizing objectives	1	2	3	4	5	6
7.	Reflecting on institutionalization including: * quality of life indicators * early intervention reducing the likelihood of institutionalization * adherence to family centered principles	1	2	3	4	5	6

Intervention

8.	Selecting assessment instruments based on the decision making purpose	1	2	3	4	5	6
9.	Administering developmental assessments in all developmental domains including: * interpreting the psychometric properties * adapting the assessment * interpreting the results of the assessment * communicating the results of the assessment	1	2	3	4	5	6
10.	Creating an Individualized Family Service Plan based on the components defined in the federal guidelines	1	2	3	4	5	6
11.	Implementing the IFSP including all of the following components: * a flexible agenda * strategies for generalization * adult learning principles * data collection	1	2	3	4	5	6
12.	Creating intervention programs to include: * task analysis or instructional sequence * measurement procedures and criteria for achievement * baseline and progress data * instructional routine including presentation, pacing and closure * generalization strategies * procedures for parents to implement in the daily routine	1	2	3	4	5	6
13.	Using effective intervention delivery including: * adhering to the child's schedule * social competence * communication and socialization * maintaining motivation * use of incidental teaching and the environment * integrating skill domains * data collection	1	2	3	4	5	6
14.	Utilizing a variety of teaching and facilitation procedures	1	2	3	4	5	6
15.	Incorporating assistive technology into an intervention plan	1	2	3	4	5	6
16.	Using effective handling, lifting and carrying techniques for an infant/toddler with motor disabilities which includes ensuring the family understands the techniques	1	2	3	4	5	6
17.	Using appropriate positioning techniques including: * the rationale for specific positions * the rationale for any adaptive equipment * ensuring the family understands the techniques	1	2	3	4	5	6

18.	Creating an effective feeding plan which includes: * proper positioning * ensuring the family understands the techniques	1	2	3	4	5	6
19.	Integrating social competence objectives into the IFSP	1	2	3	4	5	6
20.	Designing and implementing sleep interventions	1	2	3	4	5	6
21.	Designing and implementing behavioral interventions	1	2	3	4	5	6
22.	Describing the etiologies and possible implications of a variety of medical and developmental disabilities, and current intervention techniques and modifications	1	2	3	4	5	6
23.	Describe seizure disorders including effects of medications, intervention during a seizure, and data collection	1	2	3	4	5	6
24.	Developing a home health care plan for an infant or toddler with medically complex needs	1	2	3	4	5	6

Service Model

25.	Facilitating an IFSP or team staffing	1	2	3	4	5	6
26.	Evaluating curriculum guides designed for infants and toddlers including: * psychometric properties * coverage or scope * functional adaptations * potential as an assessment-to-teaching device * appropriateness of instructional materials * utility in an integrated setting	1	2	3	4	5	6
27.	Consulting to team members, including the family, using adult learning principles and effective communication skills	1	2	3	4	5	6
28.	Describing the implications of state and federal laws that affect infants and toddlers with disabilities and their families	1	2	3	4	5	6
29.	Training others in the major functions of his/her discipline and the developmental concepts traditionally covered by that discipline through use of adult learning principles	1	2	3	4	5	6
30.	Community mapping on both a regional and family level	1	2	3	4	5	6
31.	Creating a collaborative partnership with another agency to benefit families	1	2	3	4	5	6

32. Developing a program philosophy regarding delivery of services, child and family development, and transdisciplinary teaming 1 2 3 4 5 6

33. Creating a plan for service delivery encompassing: 1 2 3 4 5 6
* program philosophy
* orientation for families and staff
* community linkages
* assessment procedures
* curriculum development
* staffing patterns
* staff development
* evaluation of service delivery

34. Collaborating and mentoring with professionals to enhance practicum skills and develop a self evaluation process 1 2 3 4 5 6

35. Transmitting professional knowledge and information on early intervention topics by developing training materials, references and resources in a class format 1 2 3 4 5 6

36. Advocating for an individual, program or technique, or expansion of services 1 2 3 4 5 6

Environment

37. Assessing early childhood environments for developmentally appropriate practice and making recommendations for enhancement 1 2 3 4 5 6

38. Adapting environments to facilitate development 1 2 3 4 5 6

39. Designing and scheduling group environments for infants and toddlers based on: 1 2 3 4 5 6
* space
* duration of interventions
* individual and small group activities
* active participation of all children
* programming integrated, functional skill use
* consultation and meetings
* communication with families
* data collection procedures

40. Observing an infant in the NICU including: 1 2 3 4 5 6
* medical status
* autonomic, motor, state and interactional regulation
* interventions currently implemented
* recommendations for intervention

41. Developing a transition plan as a sending and receiving agency 1 2 3 4 5 6

APPENDIX B

ADVISORY BOARD

University of Connecticut Health Center
Disvision of Child and Family Studies

Preservice Training of Pediatric Residents
and Early Interventionists

"PERSONNEL STANDARDS FOR BIRTH TO THREE PROVIDERS"

Meeting of the National Advisory Board
September 30, 1997
Farmington, Marriott
Farmington, Connecticut

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

Personnel Standards for Birth to Three Providers
September 30, 1997 - Farmington Marriott
Farmington, Connecticut
Agenda

9:00 a.m.	Welcome and Introductions	Participants
9:20 a.m.	History of Infant Toddlers' Personnel Preparation Project	Mary Beth Bruder
9:30 a.m.	Overview of the Day	Peggy Hayden
9:45 a.m.	Credentialing Processes in Other States • North Carolina - Patty Pierce • Kentucky - Vicki Stayton & Mary Louise Hemmeter • Virginia - Beverly Crouse • Illinois - Jeanette McCollum • Massachusetts - Karen Welford	Facilitated by Peggy Hayden
12:00 Noon	Lunch	
1:00 p.m.	Status of Personnel Needs in Connecticut	Mary Beth Bruder
1:20 p.m.	Recommendations for CT • What did we learn? • What questions do we have?	Peggy Hayden
1:50 p.m.	Break	
2:00 p.m.	Large Group Sharing on Learnings and Questions	Peggy Hayden
2:45 p.m.	What are ideas that we have heard that we think would be beneficial for further investigation in CT?	
3:40 p.m.	Next Steps, Wrap-up and Evaluation	Peggy Hayden
3:55 p.m.	Closing Remarks	Mary Beth Bruder
4:00-4:30 p.m.	Adjournment	

Expected Outcomes: Participants will have

1. a common understanding of the development and implementation of credentialing processes in other states and
2. recommendations for the lead agency re: the possibility of a credentialing process for service providers in the CT Birth to Three System.

An Equal Opportunity Employer

Participant List
Personnel Standards for Birth to Three Providers
September 30, 1997
Farmington Marriott
Farmington, Connecticut

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APPENDIX C

CURRICULUM CONTENT

University of Connecticut Health Center
School of Medicine

COURSE TITLE: **Families of Infants and Toddlers**

COURSE INSTRUCTORS:

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(see next page for list of additional instructors)

COURSE OBJECTIVES:

At the end of this module, the participant will be able to:

1. Identify family system components and influences in a variety of families.
2. Identify external influences on family systems.
3. Identify coping strategies of families.
4. Apply adult learning principles when working with families.
5. Identify and utilize the various family assessment models.
6. Communicate effectively with families to identify resources, priorities, and concerns.
7. Assess parent-child interaction.
8. Identify and utilize social support networks of families.
9. Communicate the developmental implications of different disabilities to families.
10. Collaborate with families in creating family and child outcomes and objectives.
11. Develop a responsive service delivery system based on the IFSP.
12. Integrate intervention into activity settings and daily routines.
13. Evaluate the impact of intervention on a family system.
14. Identify ethical issues related to early intervention.

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COURSE REQUIREMENTS:

The following assignments will be required:

1. Reaction to Readings: The participant will prepare a 2-3 paragraph reaction to the readings for each class. The reaction will include positive and negative aspects of the reading and the overall utility of the reading.

2. Competencies: Family related competencies should begin under the supervision of Gerri Hanna. These are attached.

COURSE SCHEDULE: *5:00 p.m. to 9:00 p.m.*
Orientation class: Saturday, January 16 - 10:00 a.m. to 2:00 p.m.

Date	Topics	Discussion Group Readings	Required Readings
	1.0 Family Systems Theory	Andrews & Andrews, 1995 Powers, 1993 Rosin, 1996	Featherstone, 1981 Roberts, Rule & Innocenti, 1998, Ch. 1
	1.1 Family Members		
	1.1.1 Fathers	Turbiville, Turnbull & Turnbull, 1995	
	1.1.2 Children	Frank, 1996	
	1.1.3 Grandparents	Beverly, 1998	
	1.2 Cultural Considerations	Hyun & Fowler, 1995 Katz & Scarpati, 1995 Nugent, 1994 Sontag & Schacht, 1994 Bennett, Zhang & Hojnar, 1998	
	1.3 Families with Special Needs		Roberts, Rule & Innocenti, 1998, Ch. 2
	1.3.1 Families with Mental Retardation	Espe-Sherwindt & Crable, 1993 Feldman, 1998	
	1.3.2 Families with Mental Health Needs	Barnett, 1997	
	1.3.3 Families with HIV	Lesar & Maldonado, 1994	
	1.3.4 Families and Substance Abuse	Gottwald & Thurman, 1994	
	1.3.5 Teen Parents	Fewell & Wheeden, 1998	

Date	Topics	Discussion Group Readings	Required Readings
	2.0 The Role of Social Support		Dunst, Trivette & Jodry, 1997
	2.1 Stress and Coping	Chedd, 1996 Hanline & Daley, 1992	Affleck & Tennen, 1991
	2.2 Situational Stress		
	2.2.1 NICU	Meck, Fowler, Claflin & Rasmussen, 1995	
	2.2.2 Special Health Care Needs	Gabor & Farnham, 1996 Lesar, Gerber & Semmel, 1995	
	2.2.3 Different Disabilities	Chen, 1996 Jamieson, 1995 Wallander & Noojin, 1995	
	2.3 Resiliency	Letourneau, 1997 McNurlen, 1996 Singer & Powers, 1993	Singer & Powers, 1993, Ch. 1 Zahorchak, 1998
	2.3.1 Parent to Parent	Santelli, Turnbull, Sargeant, Lerner & Marquis, 1993 Powell, Batsche, Ferro, Fox & Dunlap, 1997	
	2.3.2 Other Mediators	Dunst, Trivette & Mott, 1994 Smith, Gabard, Dale & Drucker, 1994 Poulsen, 1993	

Date	Topics	Discussion Group Readings	Required Readings
	3.0 Family Assessment		
	3.1 Family Interviews		
	3.1.1 Communication Skills	Walker & Singer, 1993 Beckman, Frank & Stepanek, 1996	Beckman, Frank & Newcomb, 1996
	3.1.2 Priorities, Resources and Concerns	Stepanek, Newcomb & Kettler, 1996 Schuck & Bucy, 1997 Bernheimer & Keogh, 1995	
	3.2 Assessment Protocols		
	3.2.1 Family Perception of Child Needs	Ireton, 1996 Suen, Logan & Bagnato, 1995	Trivette, Dunst, Deal, Hamby & Sexton, 1994
	3.2.2 Stress and Support	Baxter & Kahn, 1996 Dunst, Trivette & Hamby, 1994	
	3.2.3 Interactional Competencies	Baird, 1997 Mahoney, et al., 1998 McCollum & McBride, 1997 Schultz-Krohn, 1997	Munson & Odom, 1996
	3.2.4 Activity Settings		Dunst, et al., 1998
	3.2.5 Models		

Date	Topics	Discussion Group Readings	Required Readings
	4.0 Implementing the IFSP		
	4.1 Collaborative Outcomes	Beckman & Stepanek, 1996 Filer & Mahoney, 1996 McWilliam, et al., 1998 Dinnebeil & Rule, 1994 Trivette, Dunst & Hamby, 1996 Turnbull & Turnbull, 1997, Ch. 9 Boone, McBride, et al., 1998	Alvares, 1997
	4.2 Objectives and Strategies		Roberts, Rule & Innocenti, 1998, Ch. 3
	4.2.1 Support Needs	Dunst & Deal, 1994 Gowen & Nebrig, 1997	
	4.2.2 Informational Needs	Roberts, Akers & Behl, 1996	
	4.2.3 Intervention Needs	Appl, Fahl-Gooler & McCollum, 1997 Dunst, Trivette & Deal, 1994 Kaiser, Hancock & Hester, 1998 McDonough, 1993 McWilliam, Winton & Crais, 1996, Ch. 7	
	4.2.4 Service Coordination	Dinnebeil, Hale & Rule, 1996 Dunst, Trivette, Gordon & Starnes, 1993	

Date	Topics	Discussion Group Readings	Required Readings
	4.2.5 Advocacy	Behl, Akers & Roberts, 1997 Bosch & McWilliam, 1997 Turnbull & Turnbull, 1997, Ch. 15	
	5.0 Evaluation Models	Brinker, 1992	Roberts, Rule & Innocenti, 1998, Ch. 6
	5.1 Data Collection	McBride & Peterson, 1997 McWilliam, Lang, Vandiviere, Collins & Underdown, 1995	
	5.2 Quality Assurance	McNaughton, 1994 Murphy, Lee, Turnbull & Turbiville, 1995	
	5.3 Fidelity of Intervention	Hadadian & Merbler, 1995 Judge, 1997	
	Ethics	Able-Boone, 1996 Bowe, 1995 Ohlson, 1998 McWilliam, Tocci, & Harbin, 1998	

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University of Connecticut Health Center
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COURSE TITLE: **Interventions Through Teaming**

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COURSE OBJECTIVES:

At the end of this module, the participants will be able to:

1. Describe different models of teaming;
2. Identify individual influences on team process;
3. Identify external influences on team process;
4. Identify the phases of team development;
5. Facilitate problem solving within a team;
6. Utilize a variety of assessment techniques to create an integrated assessment within the context of a team;
7. Assess infants and toddlers in all developmental domains;
8. Develop outcomes and objectives for an IFSP within a team context that includes the family;
9. Develop interventions that integrate all developmental areas into family identified activity settings;
10. Implement interventions with families within a context of a team;
11. Consult effectively with team members, including families, to implement intervention;

12. utilize conflict management techniques within a team;

13. Evaluate the effectiveness of interventions within a team context.

COURSE REQUIREMENTS:

The following assignments will be required:

1. Reaction to Readings: The participant will prepare a 2-3 paragraph reaction to the readings for each class. The reaction will include positive and negative aspects of the reading and the overall utility of the reading.

2. Competencies: Family related competencies should begin under the supervision of Gerri Hanna.

COURSE SCHEDULE:
Wednesday

Interventions Through Teaming

Class	Dates	Topic	Readings	Required Readings
1		Working Across Disciplines Types of Teams Team Process and Problem Solving Communication Strategies Team Maintenance Strategies Team Tasks	Briggs, 1997 Bruder, 1994 Bruder, 1996 Karp, 1996 McWilliam, P.J., 1996 McWilliam, R.A., 1996	Galentine & Seery, 1999
2		Team Contexts: Natural Environments	Bruder & Staff, 1998 Cripe & Venn, 1997 McNab & Blackman, 1998 Noonan & McCormick, 1993, Chapter 8 Rainforth, York, & Macdonald, 1992, Chapter 8 Wolery, 1994	Als, 1997 Hanft & Feinberg, 1997
3		Team Content: Cognition Communication	Bailey & Wolery, 1984, Chapter 8, Chapter 11 Hess, 1999 Kumin, Councill, & Goodman, 1999 Langley, 1989 McCollum & Hemmeter, 1997 Proctor & Murnyack, 1995 Wilcox & Shannon, 1996 Yoder & Warren, 1999	Wetherby & Prizant, 1996

Class	Dates	Topic	Readings	Required Readings
4		Team Content: Motor Adaptive/Self Help	Bailey & Wolery, 1984, Chapter 13 Dunn, 1996 Harris, 1997 Jones, Horn, & Warren, 1999 Rainforth & Roberts, 1996	Campbell, 1999 Horn, Jones, & Warren, 1999 Mahoney, 1999
5		Team Content: Social Competence Play	Fox, Dunlap, & Philbrick, 1997 Greenspan, 1996 Guralnick, 1999a Guralnick, 1999b Lifter, 1996 Odom & Munson, 1996	Guralnick & Neville, 1997
6		Assessment Protocols Across Disciplines, Contexts, Disabilities and Families	Barrera, 1996 Boris, Aoki, & Zeanah, 1999 Gunnar & Barr, 1998 Haney & Cavallaro, 1996 Judge & Parette, 1998 Langley, 1996 Miller & Hanft, 1998 Miller & McNulty, 1996 Umbreit, 1996	Greenspan, Meisels, & 0-3 Workgroup, 1996

Class	Dates	Topic	Readings	Required Readings
7		Intervention Protocols Across Disciplines, Contents, Disabilities and Families	Calderone & Greenberg, 1997 Chen, 1996 Cole, 1996 Davidson & Harrison, 1997 Dawson & Osterling, 1997 Halle, 1998 Noonan & McCormick, 1993, Chapter 7, Chapter 9 Rule, et al., 1998 Strain, 1999	Bruder, 1997 Filla, Wolery, & Anthony, 1999 Noonan & McCormick, 1993, Chapter 6
8		Evaluation Protocols Across Disciplines, Contexts, Disabilities and Families	Bruder, Staff, & McMurrer, 1997 Guralnick, 1998 Meisels, 1996 Sperry, et al. 1999	

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- Chapter 8 (pp 229-255) Promoting engagement and mastery
- Chapter 11 (pp 363-406) Preventing and responding to problem situations
- Chapter 13 (pp 441-480) Feeding and nutritional issues

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- Chapter 6 (pp 163-197) Basic instructional principles
- Chapter 7 (pp 199-235) Specialized instructional techniques
- Chapter 8 (pp 237-265) Intervention in natural environments
- Chapter 9 (pp 267-285) Group instruction

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University of Connecticut Health Center
School of Medicine

COURSE TITLE: **Interagency Collaboration and Systems Change**

COURSE DESCRIPTION: This course will identify cooperative, coordinative and collaborative structures within early intervention. It will describe and analyze facilitators and barriers to collaboration and include an examination of interagency collaboration. Advocacy and systems change strategies will also be described and applied to early intervention.

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COURSE OBJECTIVES:

At the end of this module, the participants will be able to:

1. Define collaboration.
2. Create an agency philosophy on delivering early intervention services.
3. State strategies for collaboration with families, as well as professionals both within and outside the participant's agency.
4. State strategies for locating community resources for families.
5. Identify the role and responsibilities of the service coordinator in community collaboration.
6. Identify natural environments for individual families.
7. Build community collaborations.

8. Utilize collaborative partnerships to achieve outcomes and objectives.
9. Identify transition approaches as a sending and receiving agency.
10. Enter into collaborative partnerships with other agencies.
11. Evaluate the effectiveness of a collaborative partnership.
12. Develop system change strategies for improving early intervention.

COURSE SCHEDULE:
Wednesday

INTERAGENCY COLLABORATION-MODULE THREE

Class	Dates	Who	Topic	Readings
1		Mary Beth	Transition	Bruder & Cole, 1991 Bruder & Chandler, 1996
2		Cindy, Mara	Community Mapping	Grable, 1995 Umstead, Boyd, & Dunst, 1995 Van Dyken, 1995
3		Valerie, Annie	Training Others Adult Learning Negotiation/Persuasion Consulting	Heffron, 1999 Renkl, 1999 Zemke & Zemke, 1998
4		Donna, Cathy, Cheryl	Assistive Tech	Cormier, 1999 Guidelines for Assistive Technology Judge & Parette, 1998 Knoff, 1998 Lynn, 1985 Parette, Hoffmann, & VanBiervliet, 1994 Smith & Swinth

5	Vicky, Jody Donna, Elaine	Medical Home Family Resource Centers	Darcey School Parent Center Log Book State and National Resources for Parents Rho, 1995 Patterson, Trivette, Gordon, & Jodry, 1998 American Academy of Pediatrics Web Site Gadomski, Jenkins, & Nichols, 1998 Rappo, 1997 Zanga, 1995
6	Carl Dunst	Re Thinking Early Intervention	Dunst, Bruder, Trivette, Re Thinking Early Intervention,Unpublished Manuscript

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APPENDIX D

COMPETENCIES

Program Competencies

Descriptor	Program Task	Criteria
1. Family Assessment	The participant will:	
	a. Review a minimum of three (3) family assessments (needs, social supports, functions, daily routine, adaptation and coping).	a. Written reviews will include the strengths and limitations, the mode of assessment, and examples of appropriate situations to use each assessment. Reviews will be submitted and discussed with the supervisor.
	b. Complete one family assessment for the purpose of developing goals for the IFSP.	b. A written report of the assessment results will be submitted to and discussed with the supervisor. The report will be shared with the family. The report and discussion must be sensitive to family issues and enhance the family's capacity to facilitate the development of the child.
2. Family Interview	The participant will conduct a family interview for the purpose of developing outcomes for the family's IFSP.	
	a. Plans for the interview will include the following components (within a flexible agenda): - Introduction - Priorities, Concerns, and Resources - Summary - Closure	a. The supervisor will review the agenda prior to the participant conducting the interview.
	b. During the interview the participant will demonstrate the appropriate use of communication skills: - Effective Listening - Effective Inquiry - Effective Reflection of Feelings - Effective Reflection of Content	b. The supervisor and parent will document the effectiveness of the participant's communication skills on a performance checklist.

Descriptor	Program Task	Criteria
3. Interviewing a family representing a culturally or linguistically different heritage than the participant	The participant will interview a family with a child with a disability who has newly migrated or immigrated to the U. S. for the purpose of learning about the families culture.	The participant will present a written summary of the following to the supervisor - when this family migrated and why; - what community services this family is receiving; - what supports and services are still needed by the family; - culturally sensitive strategies to use with the family for effective intervention.
4. Child Care	The participant will, provide child care for a family who has an infant or toddler with a disability. The family may choose to remain home while the care is provided. The purpose of the child care task is to give participants a sense of daily life with a child with disabilities.	A total of six hours of child care will be delivered in one or more visits. The family will complete an evaluation of the child care delivery, and the participant will complete a diary about the child care including their reflections about integrating interventions into the daily routine of the family.
5. Parent-Child Interaction Assessment	a. The participant will review a minimum of three (3) parent-child interaction assessments.	a. Written reviews will include the purpose, strengths and limitations of the assessment, the mode of assessment and appropriate situations to use each assessment. Reviews will be submitted and discussed with the supervisor.
	b. Complete one interaction assessment on a family for the purpose of assisting in the development of the IFSP.	b. A written report of the assessment results will be submitted to and discussed with the supervisor. The report will be shared with the family. The report and discussion must be sensitive to family issues and enhance the parent's capacity for interaction with his/her child.

Descriptor	Program Task	Criteria
6. Child Assessment Selection	The participant will describe assessment techniques relevant to each of the following decisions: a. Screening b. Evaluation c. Assessment for intervention d. Defining short-term objectives e. Identifying effective instructional procedures f. On-going assessment of progress g. Program evaluation	The techniques must be described in writing and include: a. Purpose b. Information gathering activities c. Specific instruments to be used d. Procedures delineated e. Limitations identified The techniques will be discussed with the supervisor.
7. Child Developmental Assessment	The participant will review a minimum of three developmental assessments and administer the following: a. One developmental assessment to two infants or toddlers the same age, one having delays. The assessment will be done in partnership with at least one other discipline; b. A Piaget sensorimotor assessment to two infants under 18 months of age; one having developmental delays. (Piaget Stages of Cognition)	A written summary of each developmental assessment will be completed. The summary will address the purpose of the assessment, the psycho-metric properties of the assessment instrument, the strengths and limitations of the assessment instrument including adaptations and scoring tables. The assessment of the children will be written up in report format, emphasizing the integration of developmental skills, the strengths of the child, and adaptations used to help the child. Written score sheets, summaries of the results and implications for programming will be submitted to and discussed with the supervisor.
8. IFSP Family Outcomes and Objectives	The participant will, in collaboration with the family and other members of the intervention team, develop individualized outcomes and objectives to meet the needs of the family (using the areas of support, information and intervention as organizers).	The outcomes will reflect the concerns identified by the family during the assessment process. The objectives will be operationalized and included in the IFSP.

Descriptor	Program Task	Criteria
9. Individualized Family Service Plan	The participant will, in collaboration with the family and other team members, write an IFSP that includes the following components: a. Statement of the infant's/toddler's level of development (cognitive, communication, social, motor and adaptive) in integrated terms; b. Statement of the family's resources, priorities and concerns related to enhancing the child's development; c. Statement of outcomes expected to be achieved for the child and family; d. Objectives, procedures and timelines for determining progress; e. Specific early intervention services necessary to meet the unique needs of the child and family including the method, interventionist(s), frequency, and intensity of services; f. Projected dates for initiation of services and the anticipated duration of services; g. Name of the service coordinator who is responsible for implementation of the plan and coordination with other agencies; and h. A transition plan for the family's passage to the child's next environment.	The outcomes and objective delineated in the IFSP will correspond to the goals prioritized by the family and the intervention team. A summary and agenda of the IFSP meeting will be submitted to the supervisor.
10. Facilitation of an IFSP or Team Staffing Meeting	The participant will facilitate an IFSP meeting or a team staffing.	A written summary be submitted and discussed with the supervisor. It will include a detailed agenda, minutes, a meeting summary and process summary. The participant will evaluate what could have resulted if the process was different than what occurred and future plans for the team and family.

Descriptor	Program Task	Criteria
11. Family Service Delivery	The participant will, after consulting with the intervention team and family, implement family related objectives from the IFSP during three face to face implementation visits.	Plans for intervention contacts will be approved by the supervisor. The contacts will include: - a flexible agenda - objectives - materials used to meet the objectives - on-going data collection to document progress or the need for changes in methods, materials or the objective - strategies for generalization - adult learning principles Following each implementation contact, the participant will write a reflection evaluating the outcomes of the contact (including parent perception) and delineate plans for the following contact.
12. Curriculum Evaluation	The participant will complete a written evaluation of three curriculum guides designed for use with infants and toddlers. The evaluation will include: a. Basic information - author, publisher, field test data, psychometric properties, cost, etc.; b. Coverage or scope - domains covered, age range, intended population; c. Format - ease of use, skill sequencing vertically, horizontally or spiral, cross-referencing; d. Use of behavioral objectives; e. Degree of task analysis; f. Functional adaptations; g. Potential for use as assessment/teaching device; h. Capacity to monitor performance; I. Appropriateness of instructional materials; j. Adequacy of established criterion levels; k. Programs for generalization and maintenance; l. Provides functional alternatives; m. Utility in natural setting.	The written evaluation will use examples from the curriculum materials to illustrate points critiqued. The product will be discussed with the supervisor.

Descriptor	Program Task	Criteria
13. Child Intervention Plan	The participant will write three intervention plans from assessment results, observations, and family interviews. The plans should be derived from IFSP outcomes and objectives. Each intervention plan will include the following components: a. The intervention objective; b. Task analysis or instructional sequence; c. Measurement procedures; d. Criteria for achievement of objective; e. Baseline performance data; f. Delineation of the instructional routine (presentation, pacing, closure); g. Progress data; h. Procedures to ensure generalization and maintenance; I. Procedures for parent implementation into daily routine. J. Procedures for implementation across all natural environments.	The plans will be judged acceptable by the supervisor prior to implementation, will be written according to established format, and will maintain performance data and program modifications. Each plan will be implemented over three months. Implementation of the program will be evaluated through the use of a performance checklist. Parents will rate functionality, ease of implementation in daily routine and evaluation of the intervention.
14. Intervention Delivery	The participant will, when presented with 1) individual, 2) small group and 3) large group instructional responsibilities, demonstrate effective intervention delivery by: a. Adhering to an infant's/toddler's schedule; b. Promoting and extending engagement/social competence; c. Creating opportunities for communication and socialization; d. Maintaining each infant's/toddler's motivation; e. Employing incidental teaching; f. Using the environment and redirection to manage behavior; g. Integrating skill domains during activity; h. Following a written program with data collection; i. Summarizing current data.	Intervention delivery will be evaluated with a performance checklist completed by the supervisor for two observations of each of the three settings.

Descriptor	Program Task	Criteria
15. Intervention Procedures	The participant will demonstrate the capacity to utilize a variety of teaching and facilitation techniques to promote infant/toddler competence. The participant will match appropriate assistance techniques to instructional contexts. Intervention procedures should sample a variety of presentation formats (errorless learning) and levels of assistance (graduated guidance, least prompts) using natural reinforcement, cues, schedules and techniques.	Procedures and techniques will be judged by, and discussed with, the supervisor. The procedures will match the content, criteria and conditions in the instructional objective. At least one back-up strategy will be specified for each presentation, assistance strategy and reinforcement technique utilized. The procedures will be observed and evaluated through a performance checklist completed by the supervisor for a minimum of six observations conducted under competency 14.
16. Assistive Technology	The participant will be responsible for using assistive technology with two infants or toddlers with disabilities. Each will have an intervention plan delineating the appropriate assessment, prescription, implementation and evaluation. One child chosen should have both cognitive and motor delays.	The intervention plans will reflect the incorporation of technology into the child's IFSP. A written plan will include: a. Research relevant information on the technology/product; b. Technology assessment including family preference; c. The intervention objectives and intervention procedures; d. Evaluation of the program; e. Incorporation of the technology into the daily routine.
17. Handling, Lifting and Carrying	The participant will demonstrate effective handling, lifting and carrying techniques for an infant/toddler with motor disabilities. The participant will: a. State information to consider prior to handling or carrying the infant/toddler; b. Observe a competent handler; c. Handle and carry the infant; d. State the rationale for the methods used; e. Ensure that the family understands and can implement handling, lifting and carrying needs.	The performance will be rated acceptable by the supervisor and conform to the components on the performance checklist.

Descriptor	Program Task	Criteria
18. Positioning	The participant will demonstrate effective positioning techniques for an infant/toddler with motor disabilities. The participant will: a. Solicit background information necessary; b. Observe and work with a competent handler; c. Inhibit abnormal reflexes through positioning; d. Use facilitation techniques as appropriate; e. State the rationale for each position and demonstrate each position: - supine - prone - side lying - side sitting - supported sitting - supported standing f. State the appropriate length of time in each position for a specific infant/toddler; g. Employ adaptive equipment to facilitate each position; h. Justify the use of any adaptive equipment; i. Individualize the equipment to promote the infant's/toddler's participation; j. Ensure that the family understands and can implement positioning needs.	The performance will be rated acceptable by the supervisor and conform to the components on the performance checklist.

Descriptor	Program Task	Criteria
19. Feeding	The participant will demonstrate an effective feeding intervention with an infant or toddler with disabilities. The participant will: a. Determine the presence/absence of each of the following patterns/reflexes: - abnormal breathing - abnormal suck/swallow - gag reflex - rooting reflex - abnormal tongue movement - bite reflex - abnormal chewing - need for jaw stability - retracted lip and cheek muscles; b. Feed one infant/toddler under the supervision of a competent feeding interventionist. Demonstrate use of positioning techniques and use of adaptive equipment/devices to inhibit abnormal patterns/reflexes; c. Use facilitation techniques as needed; d. Ensure the family understands and can implement feeding techniques.	Performance will be rated as acceptable by the supervisor on the performance checklist. The family will rate the ease and comprehension of implementation.
20. Integration of a Social Competence Curriculum into an Intervention Plan	The participant will integrate social competence objectives into an intervention plan. The participant will: a. Administer the Assessment of Peer Relations to determine social competence objectives for an infant or toddler with disabilities; b. Design and implement and intervention that integrates social competence objectives with other developmental objectives stated on the IFSP; c. Communicate the intervention techniques and child's abilities to the family; d. Collect data on intervention.	Plan will be approved prior to implementation by supervisor. Implementation phase may be through direct service, or consultation with family or group teacher through observation and feedback. Supervisor, parent and/or group teacher will rate curriculum application as acceptable using a checklist.

Descriptor	Program Task	Criteria
21. Sleeping Issues	The participant will provide consultation to a family with an infant or toddler with sleeping issues. The participant will: a. Determine a baseline of sleeping habits of the child and family; b. Design and implement intervention, through consultation with the family, to address sleeping issues; c. Evaluate intervention through data collection and parent's ease and comfort of implementation.	Plan will be approved prior to implementation by supervisor. Performance will be rated by family for comprehension and ease of intervention. Participants will utilize adult learning principles and effective communication when consulting with the family.
22. Behavior Issues	The participant will create an intervention for an infant/toddler with behavioral issues. The participant will: a. Determine a baseline of antecedent, behavior, and consequence of each unwanted behavior including the impact of the environment; b. Design and implement intervention, through modeling and consulting with the family, to address behavioral issues; c. Collect data on the intervention for evaluation; d. Train others in the child's environment to implement the plan (e.g., parents, caregivers, childcare teachers, etc.).	Plan will be approved prior to implementation by supervisor. Performance will be rated by family for comprehension and ease of intervention. Participant will utilize adult learning principles and effective communication in consulting with the family.
23. Environmental Inventory	Each participant will complete the Infant/Toddler Rating Scale (Family Home Rating Scale) for a center-based or family day care home setting designed for infants and toddlers.	Each score will be justified with a comment. Results will be shared with the center staff or administrator.

Descriptor	Program Task	Criteria
24. Environmental Adaptations	The participant, in collaboration with team members (which includes parents) will adapt a child's natural environment to facilitate development by: a. Assessing the current environment; b. Communicating to the family and/or child care staff recommendations and rationale for adaptations; c. Implementing the adaptation; d. Assessing implementation.	The adaptation will enhance the infant's/toddler's ability to meet a specific IFSP objective. The adaptation will be easy to implement in the family's home and/or child care setting. The adaptation will be acceptable to the family and the supervisor.
25. Scheduling	The participant will outline a schedule for a natural group setting of infants or toddlers to provide intervention designed to meet an infant's/toddler's concerns from the IFSP. The schedule will: a. Describe space; b. Specify duration of interventions; c. Specify service personnel; d. Account for individual and small group instruction and activities; e. Maximize active participation for all children; f. Include meaningful interactions with typical peers; g. Program for integrated, functional skill use; h. Include regular meetings of all relevant personnel to discuss and update intervention programs and methods; I. Include consultation to group team members; j. Ongoing communication procedures with family; k. Data collection procedures.	The written plan will include all elements listed and be judged acceptable to the supervisor.

Descriptor	Program Task	Criteria
26. Neonatal Intensive Care Unit	The participant will observe an infant in the NICU and complete an observation report containing the following information about the infant: a. Medical background; b. Current medical status; c. Medical treatments; d. Descriptions of signals observed - autonomic and visceral - motoric - state - interactional capacity; e. Describe the developmental interventions used to reduce stress, promote self-regulation and interaction, and enhance proper positioning.	The observation must be at least one hour in length. The written report will be discussed with a medical consultant, the supervision and group.
27. Implications of Genetic/Medical Conditions	The participant will: a. State possible etiologies for medical and developmental disabilities; b. List the symptoms and physical characteristics; c. Describe current interventions; d. Delineate specific instructional modifications necessary to promote health and competence. Participants are encouraged to compile the information for a child receiving early intervention. Some sample conditions are: BPD, hydrocephaly, fragile X, spina bifida, William's syndrome, arthrogryposis, pediatric AIDS.	Each participant will compile information from two or more sources for two children having two different conditions: one genetic and one medical condition. Information will be synthesized to present to the family either orally or written. The family will rate usefulness and comprehension of material.

Descriptor	Program Task	Criteria
28. Seizures and Medications	The participant will, in writing, describe two seizure disorders including: a. Diagnostic procedures used; b. Medications prescribed; c. Contraindications and side effects of medications; d. Procedures used to protect a child during a seizure; e. Documentation required to monitor seizures.	Seizure disorders will be chosen from the following: - Gran Mal - Petit Mal - Focal - Infantile - Myoclonic-akinetic - Psychomotor Written performance will be acceptable to the supervisor.
29. Home Health Care	The participant will develop a home health care plan for one infant or toddler who has medically complex needs. The plan will address the following elements: a. Equipment b. Medications c. Daily routine d. Charting and data collection e. Communication systems f. Team meeting and decision making g. Integrating health and development needs into the intervention plan and daily routine.	The plan will be written and acceptable to the supervisor. The plan will adhere to health and safety regulations and to the prescriptions for the infant/toddler. The plan will be formatted in a structure easy to use by the family.
30. Transition and Discharge Planning	The participant will develop a transition plan for two infants/toddlers and their families to the next environment (hospital to home, home to group natural environment, early intervention to preschool special education).	The plans will address record keeping, confidentiality, communication, staff responsibilities of both sending and receiving programs, and family's resources, priorities and concerns.
31. Consultation	The participant will serve as consultant to team members, including the family, in one area of concern identified by team. The participant will utilize adult learning principles and effective communication skills.	The team will rate the participant's ability to communicate information understandably and comprehensively for primary interventionist and parents to effectively carry out. Ongoing evaluation will occur.

Descriptor	Program Task	Criteria
32. State and Federal Regulations	The participant will describe the implications that IDEA and Connecticut P.A. 96-185 have for infants and toddlers with special needs and their families in the areas of: a. Confidentiality; b. Assessment and placement options; c. Record keeping; d. Service delivery options; e. Parent participation; f. Individual programming; g. Interaction with non-disabled peers; h. Conflict resolution; i. Linkages with the medical home.	Performance will be judged acceptable by the supervisor.
33. Communicating Role and Knowledge Base	The participant will describe the major functions of the professional disciplines or roles of personnel providing early intervention services: - advocate - audiologist - educator - genetic counselor - neonatalogist - nurse - nutritionist - occupational therapist - ophthalmologist - paraprofessional (early intervention assistant/associate) - pediatrician - physical therapist - psychologist/psychiatrist - service coordinator - speech and language therapist - social worker	Descriptions will include information on the background, training and/or licensure required by each discipline or role. Performance will be rated acceptable by the supervisor.

Descriptor	Program Task	Criteria
34. Community Services	a. The participant will examine his/her agency's community resource file and map. Current resources will be analyzed for completeness of information. At least five (5) additional resources will be added. Information on each resource will include: - name of resource - type of service provided - eligibility criteria - fees - referral procedure - contact person and phone number;	a. The community agency file will contain a variety of services and resources available, as well as pertinent information for contact.
	b. The participant will develop a community map for a specific family being served in the Birth to Three System. Participants are encouraged to use a family from a cultural minority. The participant will: - compile information on the interests of the family, including priorities, resources and concerns - determine community resources - cross reference resources and the family's interests, considering cost, transportation issues and the family's daily routine - provide the family with a variety of community options - assist the family in accessing the resources as needed; including necessary training.	b. The community map will contain state and local providers of services for birth to three year olds and their families (e.g., Hispanic Health Council, daycare center, Visiting Nurses Association).

35. Interagency Collaboration	The participant will identify a collaborative partnership necessary for his/her agency, and enter into a partnership. The collaboration will include: a. A delineation of outcomes; b. A delineation of roles and responsibilities for each agency; c. Agreement stipulations; d. Benefits for both agencies and families.	Collaboration will be deemed necessary by program administrator and used by at least one family.

Descriptor	Program Task	Criteria
36. Program Philosophy	The participant will, in conjunction with his/her program administrator, develop a program philosophy or review and revise an existing philosophy. At a minimum, the following areas will be addressed: a. Child development; b. Family support; c. Delivery of services (with competency #37); d. Transdisciplinary team philosophy; e. Facilitation of natural environments.	The philosophy statement will be submitted to and discussed with the supervisor, as well as adopted by the program. A philosophy review will include a rationale for changes or for the reason it will remain unchanged.
37. Service Delivery	The participant will write a plan to initiate early intervention services in a community/geographic region. The plan will encompass the following elements: a. Target population b. Program philosophy c. Orientation for families and staff d. Community linkages and mapping e. Child find and screening procedures f. Assessment procedures g. Curriculum development h. Placement options across a range of natural environments i. Service scope j. Staffing patterns k. Staff development l. Evaluation design	The written plan will address all the elements listed. The plan will be realistic and acceptable to the supervisor.

Descriptor	Program Task	Criteria
38. Tour of Southbury Training School and/or Community Home Setting	The participant will observe an institutional care setting and a community home setting for adults with disabilities.	The participants will write a reflection of the institution and community care setting including: a. Quality of life indicators; b. Adherence to family centered care principles. The reflection shall be discussed with the supervisor, peer mentor and program participants. c. Early intervention's ability to reduce the likelihood of institutionalization.
39. Advocacy Project	The participation will engage in an advocacy project related to the improvement or expansion of services for infants/toddlers and their families. Participants may choose to advocate for an individual, a program or technique, or for statewide services.	The participant will submit a written outline of the advocacy plan and the records of meetings. Both the initial selection of a project and the final documentation of participation will be mutually acceptable to the participant and supervisor.
40. Teaching a Class	The participant will teach one graduate level class on content from the early intervention specialist program.	The participant will provide objectives, agenda, readings and reference list to the class instructor prior to the class. The participant will self evaluate and have class participants evaluate his/her performance.
41. Mentorship	The participant will be a mentor to another early interventionist for one program competence.	The participant will provide a plan for competency implementation and an evaluation system for the competency to the supervisor. Contact logs and evaluation data will be jointly submitted by the mentor and mentee to the supervisor.

APPENDIX E

SUPERVISORY MATERIALS

EARLY INTERVENTION SPECIALIST PROGRAM
Division of Child & Family Studies
UCONN Health Center
Farmington, Connecticut

Early Intervention Specialist Program Contract

This agreement is to confirm that ______________________________ is
Participant's Name
aware of, and will adhere to, the following guidelines as a participant in the

Early Intervention Specialist Program:

1. The participant will attend all class sessions with the exception of unavoidable situations. In these instances, the participant will inform the program coordinator by calling that s/he will not be able to attend class. No more than two (2) class sessions will be missed without special permission from the program coordinator. Accommodations will be made to make up the class sessions. *It should be noted that participants can make up a missed class by attending the alternative session.*

2. The participant will complete the stated competencies to the satisfaction of the university supervisor by the conclusion of the program on December of year______.

3. The participant will hand in written reflections of assigned readings in preparation for discussion during class.

4. The participant will engage in weekly communication with her/his program administrator and university supervisor to ensure all constituents are aware of the program's content and carryover on the job.

5. The program coordinator will arrange bimonthly observations of the participant from either her/his university supervisor and/or program administrator for feedback and discussion of both carryover of content, as well as completion of competencies.

____
Participant's Signature/Date

____
Program Coordinator's Signature/Date

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Supervisory/Mentorship Contract

Name: ________________________________ Agency: __________________________

Please delineate a plan in collaboration with your agency supervisor using both the supervision and mentorship components.

Administrative Supervision (description):

Hours (per week or month):

Tasks:

University Supervision(description):

Hours (per week or month):

Tasks:

Peer Mentorship (description):

Hours (per week or month):

Tasks:

____
Participant's Signature

____
Supervisor's Signature

____
Coordinator's Signature

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Contact Log

Competency: ____

Team Members: ____

Date	Mode of Contact (Phone, E-mail, Fax, Mail, Face to Face, Individual)	Time Spent (# of minutes)	Team Involved (Agency Supervisor, Program Supervisor, Peer Mentor, Child, Family, Other staff, Alone)	Subject of Contact (Defining goals, PreConference, Observations, Information seeking, PostConference)

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Practicum Action Plan

Task (Competency)	Steps to be Taken	Progress Made/Future Plans	Dat

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Practicum Log

Name: ______________________________ Week of: __________________

I. What have I done this past week (intervention, supervision, mentoring, completion of competencies)?

II. What have I learned and how do I feel about it?

EARLY INTERVENTION SPECIALIST PROGRAM
DIVISION OF CHILD AND FAMILY STUDIES
UCONN HEALTH CENTER

PRECONFERENCE SUPPORT SHEET

Name:______________________________ Date: ______________

Supervisor:______________________________

Participant will:

1. Identify the nature of the competency.
2. State objectives to be met.
3. Discuss with facilitator what will occur.
4. Predict how family and child will participate.
5. Consider problems with the plan.
6. Select appropriate observational techniques.
7. Discuss the observer's role.

EARLY INTERVENTION SPECIALIST PROGRAM
DIVISION OF CHILD AND FAMILY STUDIES
UCONN HEALTH CENTER

POSTCONFERENCE SUPPORT SHEET

Name:____ Date: _______________

Supervisor:______________________________________

Participant will:

1. Review his/her observations of the child and family during the visit.________

2. Compare the actual visit to the outlined plan.____________________________________

3. Examine possible influences the participant had on the situation.___________

4. Look at the data recorded during the observation.______________________________

5. Explore the attainment of objectives.____

6. Explore what he/she would do the same and different on the next opportunity.____

Peer Mentorship Postconference Support Sheet

Mentor: ______________________________ Peer: ______________________

Competency Observed: ___________________________ Date: ___________

Strengths: (specific references to aspects of competency and observation)

Questions: (clarifying observation and rationale of behavior)

Facilitation: (leading questions for reflection and self-assessment)

(Adapted from Neubert, G.A. (1988). Improving teaching through peer coaching. Fastback 277, Bloomington, IN: Phi Delta Kappa.)

EARLY INTERVENTION SPECIALIST PROGRAM
Division of Child & Family Studies
University of Connecticut Health Center

READING REACTION

Author____________________________________

Title____________________________________

Source____________________________________

Positive____________________________________

Negative____________________________________

Applications____________________________________

New Concepts____________________________________

APPENDIX F

RECRUITMENT/ORIENTATION MATERIALS
TRAINING MANUALS
EVALUATION INSTRUMENTS

TO APPLY

Professionals must have:

- Interest and motivation
- A current position as an early intervention provider
- A letter of support from the program administrator

IF INTERESTED...

Please contact Bonnie Keilty at:
Division of Child and
Family Studies
UCONN Health Center
Dowling North, MC6222
263 Farmington Avenue
Farmington, CT 06030
(860) 679-2375

Child and Family Studies
Department of Pediatrics
University of Connecticut Health Center
263 Farmington Avenue
Dowling North - MC6222
Farmington, CT 06030

Integrating Knowledge, Expanding Vision...

Early Intervention Specialist Program

**Division of Child and
Family Studies
University of Connecticut
Health Center**

EARLY INTERVENTION SPECIALIST PROGRAM

Provides a competency based program consisting of coursework and practicum experiences specific to early intervention.

Develops knowledge, skills and abilities necessary for effective early intervention.

Builds upon participant's educational background and experience to establish early intervention as a distinct career within the professional disciplines providing services:

- Audiologist
- Family Therapist
- Nurse
- Nutritionist
- Occupational Therapist
- Orientation and Mobility Specialist
- Physical Therapist
- Physician
- Psychologist
- Social Worker
- Speech Language Pathologist
- Special Educator

THE PRINCIPLES OF EARLY INTERVENTION

Three modules provide the foundation:

Family Centered Care:
A model of family participation and collaboration in evaluation, assessment and intervention.

Transdisciplinary Team Process:
A service delivery model which relies on a primary service provider integrating recommendations from team members of different professional disciplines.

Interagency Collaborations:
The design and implementation of service delivery models that integrate a child and family's needs across agency lines and responsibilities.

The three modules integrate early intervention competencies including:

- Assessment
- Intervention
- Service coordination
- Assistive technology
- Working with children with low incidence disabilities

PRACTICA

Two practica carry coursework into practical experience:

Supervisory Practicum:
Participants will complete tasks under joint supervision of project faculty and program administrator.

Peer Mentorship:
Participants will choose a peer partner with whom they will participate in mentorship activities.

LEARNING THROUGH TECHNOLOGY

Some courses will be taught through interactive **video conferencing.**

The **Internet** will also be used to send and receive information from students.

EARLY INTERVENTION SPECIALIST PROGRAM

PROGRAM

The Early Intervention Specialist Program is a federally funded project from the Department of Education to create an interdisciplinary program for early interventionists currently working in Connecticut's Birth to Three System, as well as surrounding state's Early Intervention Programs. This program was designed based on adult learning principles, integrating state of the art best practices into competency based learning with supervised, practical application.

TRAINING CONTENT

The knowledge, skills and abilities necessary for working with infants/toddlers with special needs and their families are unique to what is traditionally taught in discipline-specific higher education programs. Training necessary for all early interventionists includes:

1. A thorough knowledge of typical and atypical infant development in all developmental domains: including the integration of the developmental domains in overall functioning; the range and variability of typical development; the functional skills necessary for the next environment; and the effects of biological and environmental risk factors on development.

2. Assessment strategies: the variety of instruments and approaches used for a comprehensive assessment of an infant's developmental functioning. This includes environmental and familial factors.

3. Intervention techniques: utilizing consultation with families to implement intervention within their regular daily routine in natural environments; collaborating with families to determine community resources; and utilizing the most current research in best practice for intervention.

4. Family systems: encompassing communication and collaboration with families; the role of the family as the constant in the child's life; and incorporating family resources, priorities and concerns into all interactions with the family.

5. Communication skills: with families, team members, paraprofessionals, and interagency partners.

6. Service coordination: collaborating with all team members and other community agencies to ensure that families are empowered to make informed decisions regarding their child and family.

7. Assistive technology: services and devices to improve the functional capabilities of infants and toddlers with disabilities.

8. Working with children with low incidence disabilities: from functional assessments to adapting environments and intervention techniques.

PROGRAM DESCRIPTION

The Early Intervention Specialist Program is a 15 credit hour program implemented by an interdisciplinary faculty, as well as parents of children with special needs. The course content will be delineated into the three following modules:

1. **Family Centered Services (3 credits) :** This course will address family assessments, family systems theory, natural family supports, collaborative goal setting with families, development and implementation of the IFSP, and strategies to enhance ongoing communication with families.

2. **Transdisciplinary Teaming (3 credits):** This course will explore the knowledge and skills necessary to develop and implement the transdisciplinary team model. It will examine the benefits of transdisciplinary teaming in early intervention, team dynamics, team assessments and team intervention techniques.

3. **Interagency Collaboration (3 credits):** This course will identify cooperative, coordinative and collaborative efforts within early intervention;

describe facilitators and barriers to collaboration; assess a variety of agencies' abilities to collaborate; and detail the evolution of collaboration.

The training content (see above) will be woven into each of the three modules.

Additional requirements are two clinical practica of 30 supervised hours each.

4. **Supervisory Practicum (3 credits):** This practicum will complete all competency based tasks not addressed through the coursework. There will be weekly meetings with a project faculty advisor and the program administrator, as well as bi-weekly observations by either supervisor.

5. **Peer Mentorship (3 credits):** Each participant will pair up with another to complete activities using peer mentorship. Activities will be relevant to the early intervention needs of the community.

LEARNING THROUGH TECHNOLOGY

Half of the module sessions will be via video conferencing at regional sites throughout Connecticut. Electronic mail will be used for disseminating and receiving information, transferring documents and creating products/activities.

SCHEDULING

The Early Intervention Specialist Program will require bi-monthly classes (4 hours each) beginning January through December. Practicum and peer mentorship activities and supervision will be scheduled on an individual basis.

An Orientation session will be scheduled in January for both participants and their program administrators.

REQUIREMENTS AND APPLICATION

Interested professionals must meet the following requirements:

1. Meeting the minimum professional standard to be an early intervention professional within your specific discipline.

2. Currently working (contract or salaried) in a comprehensive Birth to Three program.

3. Have the motivation and time to commit to the program.

To apply:

1. Fill out the Early Intervention Specialist Program application.

2. Obtain a letter of support from your program administrator that includes a recommendation as well as a commitment during the supervision module.

3. Schedule an interview with the Early Intervention Specialist Program faculty.

SEND ALL APPLICATIONS AND INQUIRIES TO:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center
Dowling North, MC 6222
362 Farmington Ave.
Farmington, CT 06030

Phone: (860) 679-1500
Fax: (860) 679-1571

CONTINUING EDUCATION UNITS

Department of Education Continuing Education Units (CEUs) will be awarded at the completion of the program to those participants holding a Connecticut State Department of Education Professional Educator Certificate.

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

Division of Child and Family Studies

APPLICATION
EARLY INTERVENTION SPECIALIST PROGRAM

Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip Code: ______

Employer: ____________________

Address: ____________________

Description of Duties: ____________________

____

Home Phone: ____________ Business Phone: ____________

Social Security Number: ____________________

I. **Educational Background**: Please list highest education completed.

School:

____

Address City State Zip Code

____

Major Minor Degree Date Graduated

____

An Equal Opportunity Employer

If you are currently enrolled in a graduate program complete the following:

College ____________________

Department ____________________

Degree Program: ____________________

Number credits earned ______ Expected Date of Graduation ____________

II. **Professional Experiences:** Please list any past relevant professional experiences.

1. Position: ____________ Employer: ____________

   Address: ____________ Employment Dates: ____________

   Description of Duties: ____________________

   ____

2. Position: ____________ Employer: ____________

   Address: ____________ Employment Dates: ____________

   Description of Duties: ____________________

   ____

3. Position: ____________ Employer: ____________

   Address: ____________ Employment Dates: ____________

   Description of Duties: ____________________

   ____

III. **Other Professional Experiences:** Please list other professional experiences such as practicum, student teaching or professional training experiences.

Agency	Position	Age Group	Primary Disability

IV. **Professional certification/license (s) held:** ______________________

____

V. **Language Ability:** Do you fluently speak a language other than English?

_____No _____Yes Specify: ______________________

VI. **Professional Memberships:** ______________________

____

____

____

____

VII. **Current Interests:** In a few sentences, briefly describe your interest in seeking training in early intervention. (Use the back of this page if necessary.)

Signature: ______________________ Date: __________

Return to: Division of Child and Family Studies, UCONN Health Center, Dowling North MC 6222, 263 Farmington Avenue, Farmington, CT 06030

LETTER OF SUPPORT
(to be filled out by an administrator)

To the administrator: Please provide recommendation for

____
(applicants name)
and your understanding of the commitment necessary from you for practicum supervision as stated in the Program Description.

Signature: ______________________________ Date: ______________

Return to: Division of Child and Family Studies, UCONN Health Center,
Dowling North MC 6222, 263 Farmington Avenue, Farmington, CT 06030

Early Intervention Credential Program

For all Birth to Three Professionals!

A competency-based program of coursework and practicum experiences specific to best practices in early intervention.

Regional Classes: Participants will have the opportunity to enroll in classes offered in their geographic region.

For further information please fill out and leave at the end of the conference or mail to:
Gerri A. Hanna
Child and Family Studies
263 Farmington Aventue
Farmington, CT 06030
(860) 679-4684

Name: ____________________

Address: ____________________

____

____

Phone Number: ____________________

THE SCHOOL OF MEDICINE
OF THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

November 4, 1997

Pat Arnio
EASTCONN
B-3 Comprehensive Program
10 Commerce Avenue
Columbia, CT 06237

Dear Pat,

Beginning in January of 1998, The Division of Child and Family Studies at the University of Connecticut Health Center is offering the Birth to Three, Early Intervention Specialist Program (EISP).

This program is based upon the successful participation in and completion of coursework and practicum experience that builds upon each participant's background to develop skills and abilities necessary for effective early intervention service delivery.

I have enclosed a description of the Early Intervention Specialist Program and a brochure. I would appreciate it if you would present this exciting educational opportunity to your staff during one of your meetings and post the information in your office.

My name and telephone number is listed on the brochure. Please do not hesitate to contact me for further information. Currently, I am initiating the application process and will be scheduling applicant interviews during the beginning of December.

Thank you for your assistance.

Very truly yours,

Gerri A. Hanna
Division of Child and Family Studies

263 Farmington Avenue • Farmington, Connecticut 06030 • An Equal Opportunity Employer

Early Intervention Specialist Program
Division of Child and Family Studies
UConn Heath Center

Program Orientation

January 16, 1999
10:00 AM to 2:00 PM

10:00 to 11:00 I. Introductions-Mary Beth Bruder-Director
- **A. Orientation Activity**
- **B. Values Activity**

11:00 to 12:00 II. Program Philosophy- Mary Beth Bruder
- **A. Class Organization**
    - **1. Program Objectives**
    - **2. Course Schedule**
    - **3. Bibliography**
- **B. System for Supervision of Competencies**
    - **1. Monthly Observations- Gerri A. Hanna**
    - **2. Peer Mentorship**
    - **3. Provider Supervision**
    - **4. Saturday/Alternate Weds. Sessions**

12:00 to 12:30 Lunch

12:30 to 1:30 III. Organizing and Managing Competencies/Pre-Test
Lisa Schuler
Gerri Hanna
Candace Reynolds

1:30 to 2:00 IV. Data Collection Materials- Mary Beth Bruder
- **A. Participant Contract**
- **B. Participant Entry Survey**
- **C. Consumer Satisfaction**

V. Questions

EARLY INTERVENTION SPECIALIST PROGRAM
Division of Child and Family Studies
UCONN Health Center

PARTICIPANT ENTRY SURVEY

Name: ______________________ Soc. Sec. #: ________________

In case of emergency, contact: ______________________________

Phone: ____________________

Section One: Basic Background Information

This section requests basic descriptive information about you. You are encourage to respond to every question that may apply to your situation.

1. What is your date of birth: ________________________________

2. How do you describe yourself?

( ) Black
( ) White, non-Hispanic
( ) Asian
( ) Other (Please specify). ______________________________
( ) Hispanic/Latino
( ) American Indian or Alaskan Native

3. What is your marital status?

( ) Single ( ) Married ( ) Other

4. Do you have any children or dependents?

( ) None
( ) 1
( ) 2
( ) 3
( ) 4
( ) 5
( ) More than 5

5. Do you have a child who is presently between the ages of birth to three years?

( ) Yes ( ) No

6. What is the extent of your knowledge about infants/toddlers with disabilities? (Check all that apply).

( ) Undergraduate degree in special education or related service
( ) Graduate degree in special education or related service
( ) Information acquired through experience
( ) Independent reading and study
( ) No exposure

7. What is your primary role?

( ) Administrator
( ) Nutrition
( ) Occupational Therapy
( ) Speech and Language
( ) Psychology
( ) Special Educator
( ) Assistant Aide
( ) Physical Therapy
( ) Nursing
( ) Social Work
( ) Other: ____________________________

8. What is the extent of your experience with infants/toddlers with disabilities? (Check all that apply).

( ) Direct service provider
( ) Personal experience as a relative
( ) Personal experience having a child with a disability
( ) I have been a baby sitter/respite care provider
( ) Other (Please specify). ____________________

9. How long have you been working with young children birth to three years of age?

______________years

Section Two: Motivation

1. How did you find out about the Early Intervention Specialist Program? (Check all that apply).

( ) Brochure form the Division of Child and Family Studies
( ) Flyer from the Division of Child and Family Studies
( ) Conversation with colleagues or friends
( ) Information provided from program administrator
( ) Other (Please specify). ____________________

2. What factors attracted you to the field of working with infants/toddlers with disabilities and their family? (Check only those factors that motivated you).

( ) I am interested in infant/toddler development

( ) I have a child with disabilities

( ) I have a relative with disabilities

( ) I have a friend with disabilities

( ) I feel I have a talent for working with children with disabilities

( ) I feel this work enhances the capacity of families

( ) I enjoy children

( ) No specific reason

( ) Other (Please specify). ______________________________

3. Please rank the top five reasons why you have chosen to participate in this program (1 being the major reason, 2 being the second major reason, and so on).

_____ To become better informed about early intervention

_____ For personal enjoyment and enrichment

_____ To learn for the sake of learning

_____ To help get a new job

_____ To help to advance in my present job

_____ To better understand, and work toward solutions, for the Birth to Three System

_____ To discuss early intervention issues with colleagues

_____ Because of the transdisciplinary focus

_____ Because the location was convenient

_____ To be a better parent

_____ To integrate experience with content

_____ Other (Please specify). ____________________________

4. Please rank, in order, the five issues below that were most problematic in arranging your participation in this program. (1 being most problematic, 2 being second most problematic, and so on). Only rank those issues that were problematic.

_____ Attending evening classes
_____ Lack of child care
_____ Driving distance
_____ Transportation difficulties
_____ Friends or family attitudes
_____ Home responsibilities
_____ Job responsibilities
_____ Inflexibility of job schedule
_____ Other (Please specify). ____________________________

Section Three: Available Technology

1. Do you have access to:

( ) Internet
( ) E-mail address: ____________________________
( ) Fax number: ____________________________

SATISFACTION WITH SESSION

Name: ______________________________ Date: ____________

Session Title: ____

Please rate the following statements on a scale of 1 through 5:

1. **indicates that you strongly disagree with the statement**
2. **indicates that you mildly disagree with the statement**
3. **indicates neutral**
4. **indicates that you mildly agree with the statement**
5. **indicates that you strongly agree with the statement**

	Strongly Disagree				Strongly Agree
1. The presentation was well organized	1	2	3	4	5
2. The speaker(s) was knowledgeable about the subject	1	2	3	4	5
3. The reading materials were informative and relevant to the subject	1	2	3	4	5
4. There were opportunities provided for questions and discussion	1	2	3	4	5
5. A variety of methods and techniques were used	1	2	3	4	5
6. The information is useful to my job	1	2	3	4	5
7. Small group activities allowed for problem solving	1	2	3	4	5
8. Overall rating of the individual session	1	2	3	4	5

9. What were the benefits of this week's module to you professionally?

10. What can we add or omit from this session?

CONSUMER SATISFACTION WITH MODULE

Module: ______________________ Date: ________________________

Name of Faculty: ______________________________

Please rate the following statements on a scale of 1 through 5:

1. **indicates that you strongly disagree with the statement**
2. **indicates that you mildly disagree with the statement**
3. **indicates that you are neutral**
4. **indicates that you mildly agree with the statement**
5. **indicates that you strongly agree with the statement**

THE FACULTY:	Strongly Disagree				Strongly Agree
1. were prepared	1	2	3	4	5
2. were organized	1	2	3	4	5
3. stated clear objectives	1	2	3	4	5
4. were knowledgeable	1	2	3	4	5
5. were enthusiastic	1	2	3	4	5
6. stimulated interest	1	2	3	4	5
7. were easy to listen to	1	2	3	4	5
8. were articulate/spoke clearly	1	2	3	4	5
9. used a variety of activities that corresponded with content	1	2	3	4	5
10. maintained a challenging but comfortable pace for learning	1	2	3	4	5
11. allowed enough time for questions	1	2	3	4	5
12. sufficiently answered questions	1	2	3	4	5
13. valued my input	1	2	3	4	5
14. respected the experience and perceptions of participants	1	2	3	4	5
15. had an agenda, objectives and resources	1	2	3	4	5
16. kept on task	1	2	3	4	5
17. were available to participants for feedback and discussion	1	2	3	4	5

CONTENT:	Strongly Disagree				Strongly Agree
1. Objectives of the module were met.	1	2	3	4	5
2. All topics in the syllabus were addressed.	1	2	3	4	5
3. The materials (e.g., readings, overheads) were relevant to the class content.	1	2	3	4	5
4. Adequate illustrations and examples were used during presentations.	1	2	3	4	5
5. Time was well organized.	1	2	3	4	5
6. The information is relevant and can be applied to my work situation.	1	2	3	4	5
7. I feel I now have a better understanding of the subject presented.	1	2	3	4	5

QUESTIONS:

1. What did you find most helpful about the module?

2. What did you find least helpful about the module?

3. What additional information do you believe should be included or excluded when the module is repeated?

4. What will you do differently as a result of this module?

CONSUMER SATISFACTION

SUPERVISION MODULE

Name: ____________________ Date: ____________________

Supervisor: ________________ Agency: ________________

Please rate your university supervisor on her performance on the following scale.

1. **indicates that you strongly disagree with the statement**
2. **indicates that you mildly disagree with the statement**
3. **indicates neutral**
4. **indicates that you mildly agree with the statement**
5. **indicates that you strongly agree with the statement**

MY SUPERVISOR:	Strongly Disagree				Strongly Agree
1. made herself accessible for feedback and discussion	1	2	3	4	5
2. communicated feedback effectively	1	2	3	4	5
3. was flexible	1	2	3	4	5
4. provide qualitative feedback	1	2	3	4	5
5. provided relevant feedback	1	2	3	4	5
6. was supportive	1	2	3	4	5
7. inspired my confidence	1	2	3	4	5

SUPERVISOR EXPERIENCE

I had a(n):	Strongly Disagree				Strongly Agree
1. opportunity to complete competencies on the job.	1	2	3	4	5
2. opportunity to learn more about:					
a. normal development	1	2	3	4	5
b. impact of NICU on families	1	2	3	4	5
c. developmental and environmental interventions	1	2	3	4	5
d. teaching procedures	1	2	3	4	5
e. orchestrating a classroom	1	2	3	4	5
f. integrated therapy	1	2	3	4	5
g. interacting with families	1	2	3	4	5
h. collaboration	1	2	3	4	5
I. team development	1	2	3	4	5
j. staffing and staff development	1	2	3	4	5
3. useful experience for my professional development.	1	2	3	4	5

Please comment on the following:

Quality of supervision.

Supervisor's strengths.

Suggestions for improvement of supervisory skills.

What should a supervisor's role be?

Section Two:

COMPETENCIES:	Strongly Disagree				Strongly Agree
1. The competencies were related to the module content.	1	2	3	4	5
2. The competencies were relevant to my present job situation.	1	2	3	4	5
3. The competencies were individualized to meet my needs.	1	2	3	4	5
4. There was adequate support provided to complete the competencies.	1	2	3	4	5
5. The competencies enabled me to perform better at my job.	1	2	3	4	5
6. The criteria for the competencies were well defined.	1	2	3	4	5

CONSUMER SATISFACTION

PEER MENTORSHIP

Name: ____________________ Date: ____________________

Peer Mentor: ______________ Agency: ________________

Please rate your peer mentor on her performance on the following scale.

1. **indicates that you strongly disagree with the statement**
2. **indicates that you mildly disagree with the statement**
3. **indicates neutral**
4. **indicates that you mildly agree with the statement**
5. **indicates that you strongly agree with the statement**

MY PEER MENTOR:	Strongly Disagree				Strongly Agree
1. made herself accessible for feedback and discussion	1	2	3	4	5
2. communicated feedback effectively	1	2	3	4	5
3. was flexible	1	2	3	4	5
4. provide qualitative feedback	1	2	3	4	5
5. provided relevant feedback	1	2	3	4	5
6. was supportive	1	2	3	4	5
7. inspired my confidence	1	2	3	4	5

MENTORSHIP EXPERIENCE

I had an:	Strongly Disagree				Strongly Agree
1. opportunity to complete competencies on the job.	1	2	3	4	5
2. opportunity to learn more about:					
a. normal development	1	2	3	4	5
b. impact of NICU on families	1	2	3	4	5
c. developmental and environmental interventions	1	2	3	4	5
d. teaching procedures	1	2	3	4	5
e. orchestrating a classroom	1	2	3	4	5
f. integrated therapy	1	2	3	4	5
g. interacting with families	1	2	3	4	5
h. home visits	1	2	3	4	5
I. team development	1	2	3	4	5
j. staffing and staff development	1	2	3	4	5
3. overall effective mentorship experience	1	2	3	4	5

Please comment on the following:

Quality of peer mentorship.

Peer mentor's strengths.

Suggestions for improvement of peer mentoring skills.

What should a peer mentor's role be?

STUDENT HANDBOOK

1999

Early Intervention Specialist Program

Department of Pediatrics
Division of Child and Family Studies
UCONN Health Center

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Overview of the Student Handbook

The Student Handbook for the Early Intervention Specialist Program is designed to assist students to accomplish the course work, site participation and program competency tasks for credentialing in early intervention. In addition, the Student Handbook functions to motivate students to participate and to perform new tasks and strategies in the field within the Early Intervention Specialist Program and throughout their careers. Since students enter the program with diverse levels of expertise and experience, team participation with peer mentors from class and practicum sites is integral to the Early Intervention Specialist Program. Course work instructors and program supervisors are available to assist students to:

- plan and individualize their program;
- complete the program competency tasks;
- integrate qualitative feedback on performance and written work; and
- suggest additional resources.

The amount of time and energy students devote to program competency tasks, site participation, peer mentoring and readings depends on how well students organize, self-initiate and utilize the resources from the program.

The Student Handbook is designed to facilitate student planning and participation. The responsibility of the instructors and supervisors is to ensure that each student learns new content and skills to:

- work responsively and responsibly with families;
- motivate young children to participate;
- become valuable team members; and
- promote community participation for families and children with special needs.

Students can enhance the quality of their program through the use of resources, class participation, and the application of newly learned techniques, such as, how to adapt what the student knows to a family from another culture, a single father, or parents of triplets.

The Student Handbook consists of six sections including: Overview, Early Intervention Specialist Program, Supervision, Mentorship, Management of Program Competency Tasks, and Evaluation. Each section relates to the completion of the requirements for The Early Intervention Specialist Program. The Student Handbook gives each student and site supervisor an overview of the entire program, as well as the components and procedures established to assist students to complete the program. One unique benefit of the Early Intervention Specialist Program is the amount and the variety of resources (print, media and people) available to students. Person power is diversified through the exposure to numerous faculty (experts in the field being studied), families with a child who has special needs, site supervisors, Early Intervention Specialist Program supervisors, and peer mentors. The library at the Division of Child and Family Studies is one of the most extensive libraries on early intervention in the state. The library includes texts, curricula, and assessment tools. Course work is extended through the use of dozens of videotapes to demonstrate content as well as stimulating discussion and problem solving strategies.

Lastly, the requirements for evaluation within the Early Intervention Specialist Program are extensive because:

- students deserve a high quality program;
- the field needs expanded capacity in early intervention; and
- the program is funded through a Federal grant from the Office of Special Education and Rehabilitative Services.

The Personnel Preparation grant which funds the Early Intervention Specialist Program requires documentation of the effectiveness of a model which is founded upon prior research on personnel preparation across all content areas. Consequently, the program is obligated to document thoroughly so others can replicate the entire program or a particular portion of the program. The numerous methods of evaluation are a means for students to contribute to the field and ultimately improve the quality of services and supports provided to families and their children with special needs.

Early Intervention Specialist Program

The Individuals with Disabilities Education Act (IDEA) is an Amendment of the 1975 Education for All Handicapped Children Act (Public Law 94-142) and a central component of the federal policies that guide the education of children with disabilities in this country. Parts B and H (renamed Part C of IDEA in 1997) of this Act authorize funding for education. Part B, a mandated program, guarantees all children with disabilities, from 3 to 21 years old, a free, appropriate public education, including special education services.

Part H was enacted in 1986 under Public Law 99-457, the landmark legislation which provides services for young children under five years of age who have special needs. Part H, an elective program provided states with incentive money to "develop" a service delivery system for children with disabilities, from birth through two years and their families. Parents, researchers and advocates presented Congress with testimony of a vision of comprehensive, multidisciplinary, family-centered and community based services accessible to all infants and toddlers with disabilities and to many who are at risk for disabilities. In 1994, all states had participated in securing federal funding for early intervention under Part H. Under the Reauthorization Act of 1997, the States now will be assisted to "maintain and implement" a statewide system of service delivery under Part C. The 1997 Reauthorization Amendments did not permanently authorize Part C to the disappointment of all parents and advocates of Birth to 3 services.

The unique features of P.L. 99-457 included a shift away from Part B, the special education laws under IDEA, to focus on a family-directed approach based on research from numerous demonstration grants and research institutes. The three main tenants which make Part H (now Part C) distinct from Part B are: a capacity-building, family centered approach, endorsement of team-based decisions and interventions, and collaborative, interagency systems. In recognition of the complexities of serving families, states were required to coordinate and build systems of collaboration amongst agencies. States were given five years to implement the following fourteen program components for Part H (now Part C).

1. A definition of eligible infants and toddlers
2. A timeline to ensure all eligible infants and toddlers are served
3. A multidisciplinary evaluation of each child
4. An Individualized Family Service Plan (IFSP), including service coordination for each eligible child and family
5. A comprehensive child find system
6. A public awareness system
7. A central directory of services and resources
8. A comprehensive system of personnel development
9. A designated single line of responsibility in a lead agency
10. A policy on contracting with local service providers
11. Procedures for timely reimbursement of funds
12. Procedural safeguards
13. Policies for personnel standards
14 A system for compiling data

At the inception of the Part H (now Part C) program, personnel shortages were documented through surveys and research. Over 60% of the states reported a lack of sufficient training programs. Eighty percent of the states reported shortages in trained early intervention personnel, while all states reported a shortage of therapists. The shortages were corroborated through a national study conducted by National Early Childhood Technical Assistance System in 1994.

New skills are needed at the initial training levels, undergraduate and graduate programs at colleges and universities, as well as through inservice training for existing personnel, especially therapists. The new skills focus on early development, working with families, becoming a collaborative team member, as well as brokering resources within the community and specialty service market.

In order to meet the needs for personnel, Part H (now Part C) requires:

- restructuring existing personnel training at the college and university levels;

- the provision of inservice training for persons who are practicing in early intervention;
- recruitment of additional personnel to work with infants, toddlers and their families; and
- the development of a comprehensive system of personnel development to address current and future training needs.

The Early Intervention Specialist Program is designed to prepare students to: work with families, be effective team members, motivate young children to learn and participate in natural, inclusive settings, deliver responsive service coordiantion, and implement collaborative practices across teams and programs.

Characteristics of Early Intervention

Early intervention services and programs differ from services for school age children in a number of ways. These differences include the heterogeneous characteristics of the children served, the developmental nature of intervention goals, and the need for a flexible intervention schedule and service delivery approach. In particular, the role of the family in early intervention, the need for a team based model of service delivery, the intervention contexts which are unique to early intervention, the use of assistive technology and the need for collaborative service models across agencies and programs. Following is an overview of these essential characteristics.

Family-Centered Orientation

Each child is a member of a family (however it defines itself) and has a right to a home and a secure relationship with an adult or adults. The adult(s) create a family unit and have ultimate responsibility for caregiving, supporting the child's development, and for enhancing the quality of the child's life. The family is the constant in the child's life and the primary unit for service delivery. Early interventionists must respect the individual families they serve and the decisions of each of the families in directing their child's early intervention programs.

Parents of young children with disabilities rarely take on a parenting role with any amount of preparation for the special challenges they will face. Rather, the early days, weeks and months of parental responsibility may be spent in a blur of visits to the hospital, physician's offices and special clinics with little or no opportunity to adapt to the significant change which has taken place in their lives. While most parents report an increase in the level of stress they perceive after the birth of a child, the parents of an infant with disabilities must deal with unanticipated pressures and responsibilities that can make the parenting role appear to be overwhelming.

Parents traditionally have been an integral part of early intervention services. By far, their most significant role has been that of service providers or teachers of their children. However, this view represents a restricted view of parent participation. Parents have many diverse talents and desires which can best be expressed when the parents are presented with several options for participation ranging from program leadership roles to implementing or designing adaptations for their child.

An expanded focus on family systems theory has prompted the recommendation that early intervention programs move away from a narrow focus of the child and encompass the broader and self-identified needs of the enrolled parents. The primary goal of early intervention should be to facilitate the parents' awareness of, and adaptation to, their primary role of parenting a child with disabilities. One means of accomplishing this primary goal is to recognize the ongoing stress of parents and assist them to identify and recruit support networks. By changing the focus from child change to parent-family adaptation, both programs and parents experience beneficial results.

Family support strategies should be integral to any service delivery system for families with infants and toddlers who have disabilities. The support strategies should be both formal (e.g. assistance with insurance and financial needs; identification of respite services, training on medical equipment) and informal (e.g. identification of existing community resources; facilitation of family involvement within the school). The overriding premise of such support is that it must be individually matched to the needs of the family and the use of such strategies should be directed by the family.

Family-centered care. Family-centered care is the name of a set of beliefs, attitudes and principles applied to the care of children with special health care needs and their caregiving families. The philosophy of family-centered care is based on the premise that the family is the enduring and central force in the life of a child and has a large impact on his/her development and well-being. Nine family-centered principles guide persons who work with families to:

1. Recognize that the family is the constant in the child's life, while the service systems and personnel within those systems fluctuate;
2. Facilitate parent - professional collaboration;
3. Share unbiased and complete information with families.

4. Provide comprehensive support to families;
5. *Incorporate the child's and family's developmental needs into* service and supports;
6. Facilitate parent-to-parent and family-to-family support.
7. Recognize family strengths, individuality and respect for different methods of coping;
8. Share information and implement systems and services that are flexible, accessible and responsive to family needs; and
9. Honor the traditions and cultural practices families implement by delivering early intervention that incorporates and respects the family's practices and beliefs.

These family-centered principles form the basis for the content of course work at colleges and universities, the requirements for additional training for occupational therapists, hospital floor and room design, the mission of several agencies and departments, as well as the foundation for changing practices and regulations. In 1992, Part H (now Part C) of IDEA shifted from using family-centered to the use of family-directed because families were not participating sufficiently in the development and implementation of their Individualized Family Service Plans (IFSPs).

Being family-centered or practicing family-directed intervention does not mean that professionals throw out their knowledge and experience to defer to family preferences. Rather, a blend of the family's knowledge of their child, their priorities and professional knowledge and techniques form the basis of interventions, outcomes and strategies for implementation. A family-directed approach is guided by the nine family-centered principles in how information is presented and shared with families. Families need to learn how to weigh the pros and cons of new information and techniques while making informed choices for their child and their family. Ultimately, the joining of forces between the family and the early interventionists creates a team with the skills, knowledge and motivation to design and implement effective interventions.

In order to work effectively with infants and toddlers with disabilities, early interventionists must become aware of each caregiving family's priorities, concerns and resources. Furthermore, staff must be able to communicate with the family in order to establish collaborative goals for the child and to design appropriate interventions which can be delivered in the context of the family. A family-centered approach to providing services to children and families is thus dependent on a relationship between early interventionists and families which is based on mutual trust and respect.

Just as the population of children who are considered to have special needs is not a homogenous group, neither are the children's families. The early intervention professional serving young children with disabilities will no doubt work with a diversity of families who vary by background and economic conditions, as well as by family structure. Each family will bring unique resources to the task of parenting their child with special needs and each family will identify unique needs which must be addressed through early intervention.

In addition, early intervention programs are becoming much more sensitive to the cultural background of the enrolled families. This important variable contributes to the composition and operation of a family system. The families of infants and toddlers in the early intervention system represent all the facets of American society and cultural backgrounds. The basic cultural components that must be considered as professionals interface with families include language, communication style, religious beliefs, values, customs, food preference and taboos; any one of these factors may affect the family's perception of disabilities and use of medical, social service and other formal systems. Professionals who work [illegible] early intervention must have the ability to understand the similarities and differences between their own cultural beliefs and values and those of the families they serve. The influence of cultural norms can be more significant than the influence of a specific intervention. Early intervention must develop sensitivity to the unique role these parameters play in each family system.

Family-centered care suggests that all services revolve around the family, as it is the family who is and will be the constant in the child's life. Early interventionists need sensitivity to the changing needs of the family as it copes with the ongoing needs of the child. Empathetic staff and flexible, coordinated family-centered services are crucial to the design of any early intervention system.

Advocacy. Working with families is a privilege. In return, early interventionists have the opportunity to promote a family's skills in advocacy. During their early intervention experience, families are assigned a service coordinator or mentor who can assist them to learn how to access services and supports for their child and family. A family's service coordinator introduces the family to planning for their child and themselves as well as measuring progress, monitoring services, bridging changes between programs and learning about family rights, confidentiality, records, other services and assistance. In early intervention the service coordinator introduces the family to numerous skills which include:

- requesting that others explain their jargon
- organizing new material
- weighing and choosing options
- maintaining records
- learning how to access new services and supports
- mobilizing resources to meet a family need
- learning new advocacy strategies
- evaluating services and supports, and
- preparing for change to the next program.

The role of the service coordinator is to ensure that services and supports are being delivered as delineated on the Individualized Family Service Plan (IFSP). The IFSP should be cohesive and disseminated to all staff and programs that deliver services and supports to the child and family. The service coordinator is typically the person who teaches the family about how to access services, create communication systems across providers, evaluate services, request changes in services and supports, manage the maze of paperwork, and how to communicate effectively regarding their child's and family's priorities and needs.

Early Intervention Teams

The 1990's endorsed and expanded team approaches in business, schools, and human service work. The field learned that the capacity of a team is greater than the capacity of all of its members. With the emphasis on interdisciplinary training and a need to implement a transdisciplinary approach, team members are learning to rely on each other for specialized expertise and practical applications. Families with an effective working team learn how to participate as team members and become wise, goal-directed consumers.

While infants and toddlers with disabilities may require the combined expertise of numerous professionals providing specialized services. the coordination of both people and services is frequently overwhelming. For example, personnel having medical expertise, therapeutic expertise, educational/developmental expertise and social service expertise traditionally have been involved in the provision of services to infants and toddlers with disabilities and their families. Each of these service providers may represent a different professional discipline and a different philosophical model of service delivery. In fact, each discipline has it's own training sequence (some require undergraduate, while others require graduate degrees), licensing and/or certification requirements (most of which do not require age specialization for young children), and treatment modality (e.g., occupational therapists may focus on sensory-integration techniques). In addition, many disciplines have their own professional organization which encompasses the needs of persons across the entire life span, unlike organizations focused on a single age group (e.g., NAEYC). Nonetheless, as services for young children with disabilities continue to grow, so too does the need for professionals with expertise in working with families, motivating young children to learn in the context of their daily routines in places where children and families spend time together, and in being effective team members.

In order to improve the efficiency of the individuals providing early intervention, services should be delivered through a team approach. A group of people become a team when their purpose and function are derived from a common philosophy with shared goals. The types of teams which typically function within service delivery models for young children with disabilities have been identified as multidisciplinary, interdisciplinary and transdisciplinary. The transdisciplinary approach originally was conceived as a framework for professionals to share important information and skills with primary caregivers. This approach integrates a child's developmental needs across the major developmental domains. The transdisciplinary approach involves a greater degree of collaboration than other service models and, for this reason, may be difficult to implement. It has, however, been identified as ideal for the design and delivery of services for infants and toddlers with disabilities receiving early intervention.

A transdisciplinary approach requires the team members to share roles and systematically cross discipline boundaries. The primary purpose of the approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give and take between all members (especially the parents) on a regular, planned basis. Professionals from different disciplines teach, learn and work together to accomplish a common set of intervention goals for a child and his or her family. The role differentiation between disciplines is defined by the needs of the situation, as opposed to discipline-specific characteristics. Assessment, intervention, and evaluation are carried out jointly by designated members of the team. This usually results in a decrease in the numbers of professionals that interact with the child on a daily basis. Other characteristics of the transdisciplinary approach are joint team effort, mutual staff development to insure continuous skill development among members and role release.

Role release refers to a sharing and exchange of certain roles and responsibilities among team members. It specifically involves a 'releasing' of some functions traditionally associated with a specific discipline. For example, the physical therapist may provide training and support to the early childhood teacher to enable her to position a child with physical disabilities. Likewise, the nurse may provide training to all team members to monitor a child's seizure activities. Effective implementation of the role release process requires adequate sharing of information and training. Team members must have a solid foundation in their own discipline combined with a knowledge base that recognizes the roles and competencies of the other disciplines represented on the team.

In the transdisciplinary approach, the child's program is primarily implemented by a single person or a few persons with ongoing assistance provided by team members from the various disciplines. In most early intervention programs it is the teacher and program assistants who take on the primary service delivery role. It is also appropriate for this role to be assumed by a special education teacher who may provide services within the early childhood program on a regular basis. Related service support staff most commonly therapists, often serve as consultants to the teachers. In this way, the child's therapy, as well as other needs are integrated into the daily routine of the home and classroom. This strategy facilitates the delivery of appropriate interventions across developmental domains throughout the child's day, as opposed to having a specific speech group, fine motor group, gross motor group, etc. This does not mean that therapists stop providing direct services to children. In reality, in order for therapists to be effective, they need to maintain direct contact with the child with a disability. The provision of this team model should never be used as a strategy to justify the reduction of staff.

Although collaborative, transdisciplinary service delivery teams appear simple in concept, implementation of this strategy can be difficult because of the differences between it and more familiar structured discipline specific team structures. Barriers to the effective use of the strategy have been identified as philosophical, professional, interpersonal, and administrative. In particular, the time commitment required to implement a collaborative team model effectively across all individuals may be difficult for some early intervention programs. Additionally, many early intervention staff may not have expertise or experience in a collaborative, transdisciplinary team approach, thus influencing the feasibility of such a strategy.

Early Intervention Environments

Natural, Inclusive environments and practices. The opportunities afforded to early interventionists who are fortunate enough to work with infants, toddlers and their families are comprised of the ability to include children in natural groupings and activities from their earliest experiences. Perhaps the experience is the Lamaze reunion of a birthing class, or a Mom and tot class through the Department of Parks and Recreation, a chance to act out a story at the library, or a box to explore at the church nursery. Ensuring that families and their children participate with people in the settings where families choose to spend time is most beneficial to the family as well as to the community members.

Service coordinators and other staff are learning how supports for families that are available beyond 9 a.m. to 5 p.m. and for a period of time beyond birth to three years can make a significant difference for families and their children with special needs. These supports are intrinsically available and exist because of the desire to support and share mutual vulnerabilities, not for the pay, position or status. The continuity of long term supports in life, work and play in the same or neighboring communities is important to families. Families have aspirations for their child that are similar to the dreams other families have for their children without disabilities.

When children with special needs grow up as a part of a community, it helps typical children understand the child with special needs and support her or him through elementary, middle, and high school as well as into adult life. Children who are not segregated from their neighbors and community grow up with people who are their bankers, legislators, hair dressers and physicians. The community members learn to understand their contributions, challenges and develop respect for their courage and dignity. Families cherish the friendships and the sense of belonging their children have within their community or neighborhood.

The mission for providers of services and supports is to keep as many options and future doors open for children and families as is possible. While none of us can predict all the possibilities, each of us has an obligation to ensure that we do not limit the potentials. Early intervention providers use strategies like a daily routine format in working with families to embed therapeutic opportunities into their existing routines. The chance for follow through is greatly enhanced when interventions are integrated into existing activities and routines where families and children spend time.

A variety of factors influence the decision about the optimum service setting for an infant or toddler with disabilities. These include the location of the intervention program (i.e., urban vs. rural), the program's space allocation, the needs of the child, the transportation resources of the family and program, and the preference of the family.

Early intervention can be provided in a hospital setting, a child care setting (a center, family day care home, or a baby sitter's house), the home, and community. Not all services have to be provided at the same location, the settings may change over time as the needs of the family and child change. Clearly, there is no standard setting in which to provide early intervention. No matter where the intervention services occur, the intervention techniques and services (including assistive technology) must be transferable within all of the settings in which the child and family participate.

Many times families are restricted from participating in community activities and everyday routines if their child has a disability. Early interventionists should help the family identify the natural community settings in which the family would like to participate (shopping, church, library, etc.). Intervention routines should be used to empower the family to participate in as many of these natural environments as they wish.

Children with disabilities benefit from participating in group settings with children without disabilities, in fact, this practice, termed 'inclusion' has been cited as a quality indicator of early intervention services. Support for the practice of inclusive early intervention services was derived from a conceptual base that emphasizes the social/ethical, educational and legal reasons for the integration of young children with disabilities with young children without disabilities. As a result, both families and professionals have articulated the importance of providing interventions to young children with disabilities within group settings that also serve young children without disabilities. In particular, five interrelated service delivery developments support the expansion of early intervention into natural group environments. They will each be summarized.

First, families have become increasingly vocal about their expectations for their children with disabilities. It has been well documented that parents of young children with disabilities want their children to have the opportunity to receive services in the mainstream. These parents have also suggested that one of the most important outcomes of special education should be the development of friendships between their children and children without disabilities. Special educators, as well as other service providers for children with disabilities, are responding to expectations like these by revamping special education curricula to focus on the facilitation of social competence and friendships between children with and without disabilities. A collateral finding in this research has been that parents of young children without disabilities who have participated in inclusive preschool programs have reported positive attitudes toward this practice.

Second, there has been an increasing demand for child care services for young children. More than 11 million preschool children attend early care or school programs. This is not surprising since statistics show that 52% of women with an infant under the age of one were in the labor force and, therefore, in need of ongoing child care. This large number includes women who have children with disabilities.

In order to meet this growing need, it has been suggested that early intervention programs collaborate with child care programs and deliver services within those settings. Model demonstration projects have provided evidence for this model, providing that appropriate supports are in place. In particular, training resources are needed to increase the availability and access to child care programs to families with children with disabilities.

Third, Part H (now Part C) of IDEA has emphasized the rights of eligible infants, toddlers and preschool aged children to receive early intervention services within 'natural environments.' In particular, section 677(d)(5) of P. L. 102-119 states that the "Individualized Family Service Plan must contain a statement of the natural environments in which early intervention services shall appropriately be provided.' The definitions under Part H (now Part C) further clarify that, when group settings are used for intervention, the infant or toddler with a disability should be placed in groups with same-aged peers without disabilities, such as play groups, day care centers, or whatever typical group settings exists for infants and toddlers without disabilities. This has resulted in a redefinition of early intervention services to allow for inclusion of children with disabilities into natural group environments. Part C now explicitly calls for delivery of services in "natural environments"

> **"to the maximum extent appropriate, services will be provided in natural environments and will only be provided in other settings when services cannot be achieved satisfactorily in natural environments." Section 633 (9)(16).**

Fourth, the Americans with Disabilities Act (P.L. 101-336), prohibits discrimination against individuals with disabilities by state and local governments (Title II) and public accommodations (Title III). All state and local government operated services for children such as child care centers, pre-schools, park and recreation services, library services, etc. cannot exclude from participation in or deny the benefits of their services, programs or activities, or otherwise discriminate against a child with disabilities. Moreover, the United States Department of Justice, in their highlights of Title II state, "Integration of individuals with disabilities into the mainstream of society is fundamental to the purposes of the Americans with Disabilities Act." Among the locations defined as 'public accommodations' under Title II are: a nursery school, a day care center, or other social service center establishment, a gymnasium, health spa or other place of exercise or recreation. Early intervention services are becoming more prevalent within such entities.

Last, young children aged three to five who are eligible for special education and related services have the right to receive these services in inclusive environments through two memorandums which were issued by the Office of Special Education and Rehabilitation Services, US Department of Education. These memos reinforce the child's right to both part-time and full-time placement in programs which serve preschool children who do not have disabilities. Use of both private and public programs such as Head Start for typical children and as special education placements for children with disabilities is one strategy which has been identified to ensure a least restrictive setting.

These reasons, in combination, underscore the need to expand inclusionary educational services to young children with disabilities and their families. The Division for Early Childhood, Council for Exceptional Children has released a position statement supporting inclusion for young children with disabilities.

Assistive Technology

Assistive technology devices and services are now mandated by Public Law 100-407, the Technology-Related Assistance for Individuals with Disabilities Act of 1988. This legislation defines an assistive technology device as, "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Examples include augmentative communication devices, computers adapted with micro switches, environmental control devices, seating and positioning equipment, power mobility, and adaptive play materials. This act also provides for assistive technology services that are defined as "directly assisting an individual with a disability in the selection, acquisition, or use of an assistive technology device." These funded services: 1) evaluating an individual's technological needs; 2) purchasing or leasing equipment; 3) maintaining the devices in good repair; 4) training the individual, family members, and professionals in the use of assistive devices; and 5) coordinating the use of assistive devices with other therapies.

Part C of IDEA also lists assistive technology as an early intervention service: therefore it should be included on a child's IFSP. According to the regulations of Part H (now Part C):

> (1) Assistive technology device means any item, piece of equipment. or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities. Assistive technology services means a service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device. Assistive technology services include:
>
> (i) The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;
>
> (ii) Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
>
> (iii) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;

(iv) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(v) Training or technical assistance for a child with disabilities or, if appropriate, that child's family; and

(vi) Training or technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Assistive technology may be termed either 'low tech,' such as velcro strips on paintbrushes with extended handles, or 'high tech' such as computers, input devices like switches, keyboards and graphic tablets and output devices such as speech synthesizers. Additionally, a range of seating and mobility devices are also considered assistive technology.

The use of assistive technology as a tool for children with disabilities is an area receiving attention. Research has demonstrated that technology is an effective tool to help infants, toddlers and young children learn cause and effect and to control their environment through movement of hands and feet. Movement activated switches produce a variety of environmental consequences such as lights turning on and off. Children learn to use switches to indicate preferences and make communicative choices through speech synthesis and graphic representations of objects. Since technology expands a child's options and independence, use of technology should be incorporated throughout early intervention.

Medical assistive devices are a necessity for many children with complex health care needs. These devices replace or augment inadequate bodily function. The frequency with which children require medical technology assistance is rather low, occurring in about one in one thousand children. The Office of Technology Assessment defines a child who receives medical technology assistance as one who uses such a device and requires substantial daily skilled nursing care to avert death or further disability. These devices include respiratory technology assistance (e.g., oxygen supplementation, mechanical ventilation, positive airway pressure devices), surveillance devices (e.g., cardiorespiratory monitors, pulse oximeters), nutritive assistive devices (e.g., tube feedings, ostomies), intravenous therapy (e.g., nutrition, medication infusion), and kidney dialysis. Approximately half of medically technology-assisted children require some form of respiratory technology assistance. The field of early intervention must be prepared to use any technology necessary to enhance a child's development.

Collaborative Service Models

Early intervention requires that many agencies work together to develop joint activities focused on the development of collaborative service models. A logical extension to this requirement for services for young children with disabilities would be the design of collaborative service models to encompass the early care and education needs of all young children. The challenge would be to identify the various agencies, professionals and payment sources currently involved in the provision of such services. While interagency and cross disciplinary collaboration would be the first step toward building collaborative service models, the ultimate goal would be a seamless system of service delivery which fluctuates around a family and child's needs as opposed to artificially imposed program limitations reflective of agency and funding constraints.

Transition planning and implementation. Early intervention requires planned transitions before a child turns three years of age. However, standard practice relies on transition planning to ensure children and families prepare and benefit from other services and environmental changes in their lives. Two examples of standard transition practice are included. First, discharge planning for children coming home from the hospital is essential for parents to learn all the care routines and feel comfortable being the primary or sole care providers. Second, when children shift from a home-based service delivery model to a center-based model the routines, people and duration of intervention change.

Accommodations on the part of children and families are smoother and better understood if planning occurs ahead of time. Anticipating outcomes and barriers prepares families to make choices that are in keeping with their own routines and traditions. The joining of forces to ensure that there are no service gaps between programs is the ultimate aim in transition planning.

Early intervention regulations require a minimum of 90 days to plan a transition with families and the next provider of service. The content of the transition plan is to address: (1) a review of the potential options for the child; (2) how the family will be trained; and (3) how the child will be prepared to adjust to and function in the next environments.

There are many benefits to collaborative service delivery models. Most importantly, collaboration is a more efficient and effective use of early intervention and other services.

Program Competency Tasks

The Early Intervention Specialist Program consists of 41 program competency tasks to be completed by each student. The program competency tasks are designed to ensure an applied emphasis within the program. Programs that are individualized, comprehensive, competency-based and field responsive are more effective than traditional models of personnel preparation. The program competency tasks reflect standard practice (DEC, 1994). These program competency tasks for the Early Intervention Specialist Program are adapted from the Masters program for severe disabilities at the University of Oregon. Original early intervention program competency tasks were developed for an interdisciplinary personnel preparation grant in 1988 at UCONN Health Center.

Program competency tasks reflect content in the following areas:

Family - assessment, interaction, cultural/linguistic heritage, and outcomes;

Intervention - assessment, IFSP, intervention procedures, assistive technology, genetics, seizures and medications, health care, positioning and handling, feeding and sleeping, social competence and behavioral issues;

Service model - curriculum, regulations, roles, IFSP team, service delivery, program philosophy, advocacy, community service, interagency collaboration, and consultation; and

Environment - neonatal intensive care unit (NICU), environmental adaptations, environmental inventory, scheduling, transition and discharge planning.

Each program competency task consists of (1) a descriptor, (2) a program task or competency which describes what the student will accomplish, and (3) criteria to let the student know how her/his performance is measured and who will measure it.

Program competency tasks are designed to address both the knowledge and the application of knowledge with a family, child or team. Some program competency tasks require written reviews prior to the application of skills. The program competency task describes what is expected and how it relates to early intervention standard practice. Students are encouraged to read through the program competency tasks at the start of the course to ensure that they understand what is required of each program competency task. Students have several opportunities to discuss program competency tasks with their supervisor and to ask questions as they plan to implement and receive feedback on each program competency task.

The accomplishment of program competency tasks is organized through the documentation required. Preplanning occurs on the Action Plan which is discussed with either the program supervisor or the site supervisor. The student's performance is documented on the program competency task performance checklist by the Early Intervention Specialist Program supervisor, site supervisor or peer mentor. The student also records her/his self evaluation on the action plan, a performance checklist, and on the weekly Practicum Log.

Students perform skills related to each area of knowledge. For example, knowledge in the area of family assessment is accomplished by writing a review of three different family assessment instruments. The application for this program competency task consists of an interview with a family to gather information regarding the family's resources, priorities and concerns for the development of outcomes and strategies on the IFSP. In order to accomplish the genetics program competency task, students demonstrate knowledge by gathering information and resources from at least two different sources for a condition with which they want to become more familiar. The application portion of this program competency task requires students to locate resources and information from the medical, research and intervention / education fields. This information needs to be presented to the family in a meaningful and sensitive manner. Resources on genetic conditions should also include information for families who want to exchange support and information with other families.

Program competency tasks that require direct application of skills are measured on a performance checklist. The program supervisor is familiar with performance checklists. If a site supervisor is providing feedback, the student should review the performance checklist with the site supervisor prior to its use. Questions can be directed to the program supervisor. Students can have both the site and program supervisors provide feedback on a performance checklist. Students are also encouraged to solicit feedback from team members with whom they practice at their early intervention site.

Several observations may be necessary for a student to reach an appropriate level of competency on performance checklists. Input from the program supervisor, site supervisor and the synthesized, interdisciplinary early intervention role will assist to determine proficiency needed on program competency tasks. For example, an educator who designs instructional programs and curricula is expected to master group instruction at a higher level than a nutritionist who may consult to a group. A motor therapist is expected to design instructional plans for individuals and groups that reflect appropriate positioning and individualized motor skills embedded into routines and activity-based curriculum as well as teach team members about positioning and motor development. A social worker may be expected to implement the motor therapists individualized positioning techniques during home visits and while leading a group on feelings. Practice implementing interventions with feedback from supervisors and team members is crucial to changing habit patterns of single discipline practice.

Self-evaluation is a process, which should become automatic for all students. This process leads students to analyze their own performance, to generate new ways of intervening and to recognize their accomplishments. To assist in making self-evaluation a habit, the documentation required of student's reviews what activities the student performed and what they learned each week. In addition, students record their analysis on their action plans as preparation for their post observation conference with the supervisor who observed their performance on a specific program competency task.

Course work

The course work is presented in three modules of three credits each. Each credit consists of 10 contact hours; therefore, each module consists of 30 hours of contact time. The first module is family-centered services; the second, transdisciplinary team process; and the third, interagency collaboration. Each module is organized through a syllabus consisting of objectives, schedule, agendas for each session, references, readings and program competency tasks.

Presentation of content is based on adult learning principles. Students actively participate through the use of simulations, role-plays, critiquing videos, applying techniques with their classmates, discussions and some lecture. Readings are disseminated in advance of a topic so students can bring their questions to the class.

Application of content is required for each program competency task. Application requires students to synthesize information from course work and implement the information while working with young children and their families.

Early intervention, under Part C of the Individuals with Disabilities Education Act, states that the role of the service provider is a consultant, trainer and participant on a team to enhance the development of young children and enhance the capacity of families to meet the special needs of their children. This role definition is emphasized in the three principles of effective early intervention: family-centered care, transdisciplinary teaming, and interagency collaboration. The content for the Early Intervention Specialist Program consists of three modules to address the knowledge, skills and abilities for early intervention. This content which is embedded in family-centered care, transdisciplinary teaming and interagency collaboration includes:

1. A thorough knowledge of typical and atypical infant development in all developmental domains: including the integration of the developmental domains in overall functioning; the range and variability of typical development; the functional

skills necessary for the next environment; and the effects of biological and environmental risk factors on development.

2. Assessment strategies: the variety of instruments and approaches used for a comprehensive assessment of an infant's developmental functioning. This includes environmental and familial factors.

3. Intervention techniques: utilizing consultation with families to implement intervention within their regular daily routine in natural environments; collaborating with families to determine community resources; and utilizing the most current research in best practice for early intervention.

4. Family systems: encompassing communication and collaboration with families, the role of the family as the constant in the child's life; and incorporating family resources, priorities and concerns into all interactions with the family.

5. Communication skills: with families, team members, paraprofessionals, and interagency partners.

6. Service coordination: collaborating with all team members and other community agencies to ensure that families are empowered to make informed decisions regarding their child and family.

7. Assistive technology: services and devices to improve the functional capabilities of infants and toddlers with disabilities.

8. Working with children with low incidence disabilities: from functional assessments to adapting environments and intervention techniques.

9. Natural environments: locating and creating opportunities for infants, toddlers and their families to participate in activities and

events with other neighborhood families and with children who do not have delays or special needs.

The course work content for the Early Intervention Specialist Program is implemented by an interdisciplinary faculty, as well as parents of children with special needs. The course content is delineated in the three following modules:

1. **Family-Centered Services (3 credits):** This course addresses family assessments, family systems theory, natural family supports, collaborative goal setting with families, development and implementation of the IFSP, and strategies to enhance ongoing communication with families.

2. **Transdisciplinary Teaming (3 credits):** This course explores the knowledge and skills necessary to develop and implement the transdisciplinary team model. It examines the benefits of transdisciplinary teaming in early intervention, team dynamics, team assessments and team intervention techniques.

3. **Interagency Collaboration (3 credits):** identifies cooperative, coordinated and collaborative efforts within early intervention; describes facilitators and barriers to collaboration; assesses a variety of agencies' abilities to collaborate; and detail the evaluation of collaboration.

The methods for introducing, presenting and acquisition of the knowledge and skills for the content encompasses use of case studies, applications and simulations, activities and discussions utilizing adult learning techniques.

Supervision

Supervision is a critical component of the Early Intervention Specialist Program which functions to:

- individualize the course for each student
- link theory and practice
- provide qualitative feedback
- facilitate the integration of skills across modules
- expand skill repertoires with guided practice
- enhance the accommodation of skills to new contexts, and
- routinize the capacity of each student to self-evaluate.

Supervision is a process based on a relationship designed to produce growth and change through feedback, discussion, shared strategies, questioning and preplanning for the next intervention opportunity.

Site supervisors. Site supervisors are regularly available to provide information on specific procedures, children and families, regulations and other issues specific to the site. Site supervisors can collaborate with the student and the Early Intervention Specialist Program supervisor to help determine how and when program competency tasks are accomplished. The site supervisor can manage scheduling and matching families and children to a specific need. The responsibilities of site supervisors are to support students within the site. The support may include assistance in managing or rearranging schedules so students can participate in a variety of activities. Site supervisors may provide feedback on a particular program competency task if that has been agreed to by the Early Intervention Specialist Program supervisor.

Early Intervention Specialist Program Supervisors. Program supervisors assist students and site supervisors develop a schedule to accomplish the program competency tasks. In addition, all adaptations or any changes in the program competency tasks must have prior approval from the program supervisor. The program supervisor has the responsibility to ensure that students are integrating new material and procedures form the course work into their practice repertoire. Since program supervisors have familiarity with the course work, readings and program competency tasks, they are best suited to provide comprehensive feedback and support to students. The program supervisor is familiar with the requirements of the grant and can respond to students' questions with both substantive and procedural information. Students deserve opportunities, support and feedback that result in changes in how interventions are provided to young children and families. The purpose of the program and grant are to effect a qualitative and quantitative change in early intervention personnel. Consequently, allowing students to show us what they already know or practice is not sufficient. The program supervisor shares responsibility and accountability for students and their performance.

Mentorship

Mentorship is a unique relationship designed to enhance the skills, knowledge and interventions of the Early Intervention Specialist Program student. Mentorship consists of a match between two practitioners. The mentor usually has experience and depth of knowledge, which the mentee (student) is seeking to acquire. Typically, the mentorship is formed around a specific topic or procedure. The mentorship relationship is free from the authority another supervisor brings to supervision. Mentorship is the building of skills, knowledge and strategies between two persons who perform the same functions or have the same job responsibilities. In early intervention, service coordination is such a function. Service coordination can be learned by a physical therapist that happens to mentor with an educator or a social worker. Team members, including family members can be mentors.

Site mentors. Site mentors are team members who are working with and currently practicing what the mentee wishes to learn. Learning from someone who implements best practice is efficient, practical and provides the student a consultant for future problem solving.

Peer mentors. The Early Intervention Specialist Program endorses the use of peer mentors for several reasons, First, it is beneficial for students to hear and be exposed to the perspectives of other students. Students also build a support network through peer mentorship. This network is a place for students to check out and share ideas, as well as solicit support during the demanding and rigorous course work. Several program competency tasks lend themselves to peer mentorship. A student can literally triple the amount of information gathered if she or he chooses to work on a competency in conjunction with others. Please be sure to get clarification on specific tasks and how each task will be evaluated from your program supervisor.

Peer mentors frequently maintain their contact after the course ends. The understanding and appreciation for the amount of work that goes into accomplishing the course requirements is best understood by another peer who had the same requirements. The capacity to carry out changes also is supported through a network of peers.

Management of Program Competency Tasks

Organization. The efficient student prepares with advance organizers such as duplicate copies of performance checklists, practicum logs and a system designed to keep all course materials accessible. The course materials are organized by module. Some students have extensive work hours in addition to their family life and obligations, consequently time management, stress reduction and a plan full approach are important. Timelines, logic and frequency of use should help students organize their materials. A system of notebooks or files is recommended. The forms required for each program competency task should be reproduced and placed in the system of choice with each program competency task for efficient use. The notebooks or files will be reviewed by faculty and program supervisors twice annually as portfolios.

Each student is encouraged to read through all the program competency tasks and create a timetable for completion. The timetable can be transferred onto the student's contract. This information is essential for both the program supervisor and the site supervisor to plan their time for preplanning, observation and follow-up feedback.

Time management. Effective time management skills will assist the student with accomplishing program competency tasks, participating in class and in peer mentor arrangements, and maximizing opportunities at work sites. Planning and managing time reduces stress levels and allows the student, site supervisor and program supervisor to have productive outcomes for course work and program competency tasks.

Guidelines for time management:

1. Establish realistic timelines to accomplish program competency tasks.
2. Students should assess their needs and determine what resources and materials are needed to complete a program competency task.
3. Break the program competency task into manageable units.
4. Before beginning students should review the Action Plan Sheet with their site and program supervisors.

5. Create a checklist to help organize task components into a logical sequence and to provide the satisfaction of c completion as items are checked off.
6. Evaluate along the way so necessary changes can be made.

Students are encouraged to review each module, the readings and program competency tasks prior to investing time to complete the tasks.. Students are also expected to discuss the plan to accomplish program competency tasks with the program supervisor. The Program Task Contract is designed to assist the student pace their work during the course. The Early Intervention Specialist Program supervisor helps students link program competency tasks and course work with events at their site for practical and meaningful applications. The Early Intervention Specialist Program supervisor is the person who signs off on program competency tasks and can share the Competency Sign Off Sheet with the student and the site supervisor.

Planning is the key to effective time management. The amount of time students spend planning saves time at the implementation phase and ensures that students are organized and have back-up strategies for unanticipated events. Planning, pacing and evaluating build good time management habits.

Stress management. Students experience stress when their routines change and the demands from their environments increase. Taking an intensive early intervention course in addition to working in early intervention can be stressful. Stress can be managed and channeled. Managing stress means students anticipate the changes in their schedule and workload in order to plan for them. Proactive planning is only one means of reducing stress. Other strategies include preparing for each day by getting sufficient sleep and eating appropriately. Exercise is also another well-documented means of reducing stress. Each student should find a means of exercise that matches their schedule and level of interest and intensity.

Guidelines for stress management:

1. Be sure to eat properly.
2. Get daily exercise.

3. Keep lines of communication open with others.
4. Schedule meetings with your supervisor to discuss any problems or upcoming activities.
5. Find another participant with whom you can relate and share perspectives.
6. Set some personal time aside each week to do something you enjoy that is not related to your professional or student activities.
7. Plan your time.

Some of the course work materials can also assist in managing stress. For example, the practicum log may assist a student feel a sense of accomplishment as they record what they did for the past week, It also allows a student to preplan for the following week. Program supervisors can also suggest readings for stress management.

Documentation. Each program competency task consists of key knowledge and application for effective early intervention practice. Documentation includes a preplanning format, the actual written product or observation feedback forms and a component for self-evaluation. The documentation is required to assist students with planning time and resources, as well as to build continuous habits for planning, organizing, implementing and self-evaluating. See Appendix C for a copy of the forms used for documentation.

Evaluation

The multiple evaluation components are designed to assist students with qualitative feedback designed to create interdisciplinary early intervention practices that are family-directed, team-based, collaborative and fun, functional and age appropriate. The rigor of evaluation is important to document change in students' skill levels, knowledge and capacity to synthesize material into their current practices. Just as students focus on self-evaluation as a critical means to improve their abilities to deliver effective interventions, faculty and Early Intervention Specialist supervisors use evaluation as a yardstick to document change and to learn about whether the feedback provided is sufficient. In addition, the grant, which funds the program, requires numerous evaluation components to document appropriate[data for others to replicate or improve upon the design of the program.

Evaluation throughout the course will be rigorous. The reasons for rigorous evaluation are numerous.

1. The Early Intervention Specialist Program is accountable to provide students with a high quality program. The program needs to measure its effectiveness.

2. The Early Intervention Specialist Program is accountable to the Office of Special Education and Rehabilitative Services to fulfill contracted grant tasks in a cost effective manner.

3. In order to make changes in the program and in how early interventionists are prepared, evaluation of progress and the process is essential.

4. Multimodal evaluation across dimensions will provide feedback on: content, faculty presentations, early intervention sites, quality of supervisors and the overall program.

5. Student performance will be measured on the content during course work, the program competency tasks, and student participation as a team member and as a peer mentor.

6. Students will evaluate audio-visual materials, readings and the observations conducted such as in the Neonatal Intensive Care Unit.

7. Follow-up evaluations will be conducted to determine whether student participation in the Early Intervention Specialist Program led to lasting changes.

Course work. The overall knowledge students have of early intervention is measured prior to participation in the program and at the end of the program to document effectiveness of the curriculum in producing change in this area. Students also evaluate each session of course work to assist the faculty in improving content, techniques for delivery and practice activities. The course work presented during class is extended through competencies and site participation.

Site-Participation. The Early Intervention Specialist Program is designed so students can practice the new knowledge and skills learned during their work routines. The ability for students to experience the application and its effects on children and families is critical to the program. The evaluative components of this aspect of the program are measured through the number of contact hours the student has with their site supervisor, the satisfaction the student expresses with opportunities to accomplish program competency tasks, and the quality of the students' performance as rated by the site supervisor.

Program Competency Tasks. The program competency tasks are designed to promote effective practices for early interventionists. Each program competency task contains criteria for completion. The criteria may include a performance checklist or written reports. Students are expected to preplan using the Activity Planning Log to organize the appropriate people and resources. The program and site supervisors should plan to give feedback to the student as soon as possible after observing an activity. Site supervisors are encouraged to call the program supervisor with any questions on the performance checklist items.

The evaluation component includes pre-post assessment of overall program content, acquisition of specific module content, completion of program competency tasks, observational measures of professionalism and clinical interactions, and a review of the student's portfolio. Consumer satisfaction will be measured across sites on program competency tasks, course content and the quality of supervision.

Evaluation is a critical component for all programs. In order to determine whether the content of the Early Intervention Specialist Program is responsible for the changes in the interventions delivered by students, multiple measures are used to determine program validity. Students as the recipients of training deserve a high quality experience that makes a significant difference in the content and delivery of their interventions with children, families and team members.

Forms. Each program competency task is accomplished when the Early Intervention Specialist Program supervisor signs off on the Competency Overall Rating Sheet. The sign off means the Early Intervention Specialist Program supervisor has reviewed the following forms:

1) Supervisory/Mentorship Contract
2) Practicum Action Plan
3) Contact Log
4) Practicum Log
5) Peer Mentorship Postconference Support Sheet
6) Performance Checklists.

Practicum Action Plan. The purpose of this form is to assist the student to organize and preplan the implementation of the program competency task. The section, Steps to be taken, documents the sequence and resources needed to accomplish the program task. The section for progress and future plans is designed to document portions accomplished as well as adaptations for future implementation. Recording the date helps students track the amount of overall time to accomplish the entire program task as well as rewarding students for the steps along the way to completion.

Contact Log. This form tracks total time and types of contacts made with teams while the student works to accomplish each program task. The contact log also helps students organize and reinforces students for the small steps completed. When students record each contact they also review the process, which can lead to more efficient use of time and a quicker response to adaptations needed.

Observation checklists. Each program competency task that requires observation has a checklist specifying particular content for that program competency task. Observation checklists can be completed by the Early Intervention Specialist program supervisor, the site supervisor or a peer mentor. A student's [performance is rated from 1 (unsatisfactory) to 6 (excellent) Students should also use the checklist to self-evaluate their own performance. The Observation Checklist provides for comments and qualitative feedback as well.

Practicum Log. Each student completes the log weekly to document all their activities and their reflections regarding new knowledge and new techniques. The purpose of this form is to promote self-evaluation in a manner that assists students to integrate or accommodate new knowledge into practice.

Peer Mentorship Postconference Support Sheet. This sheet is designed to document specific student strengths on a particular program competency task. In addition, the sheets provide space to record clarifications and rationale for the interventions performed. The last portion of the form provides for self-assessment through reflection.

Supervisory Mentorship Contract. This form is completed as a contract between the student, the Early Intervention Specialist Program supervisor and the site supervisor. The form should be completed early in the student's participation. The form helps to clarify roles and commitments. It also functions to pace students on the completion of program competency tasks as well as ensuring a diversity of feedback.

Program Competency Tasks. Each program competency task lists criteria for accomplishment. Students will have several observations on some competencies completed by their site supervisor, a peer mentor and the program supervisor. Varied feedback is important and students should not expect to complete each program competency task on the first observation or checklist completed. Students also self-evaluate on completion of the program competency tasks. Typically, students are harder on themselves than the supervisors. At this level of evaluation, students receive the most individualized feedback.

Early Intervention Specialist Program. There are numerous forms students complete that are used as a measure of program effectiveness. They range from attendance and types of questions asked to the quality of written work and overall ratings of the course. At numerous junctures students evaluate the program. Consumer feedback is essential to refining the program to meet the needs of diverse adult learners. The program impact will also be measured at the student's work site by the site supervisor and other team members. Community impact will also be solicited from other agencies. The longevity and duration of change will be measured by follow-up evaluations.

t=28.12, p<.000. The mean follow-up test score for the 11 institutes that completed follow up was 83%. The overall follow-up t-score for the 11 institutes that completed follow-up was t=23.96, p<.000. The overall percentage of change across all the institutes shows that there were significant gains in knowledge. The follow-up scores point out that retention and application of training curricula was achieved. This table clearly shows that the institute trainings were effective and successful. The 8 institutes that show no follow up data were due to staff turnover, changes within the program site and participants finding steady employment outside from the program site. Appendix O provides a further breakdown of the pre/post and follow-up test scores from each individual institute.

Motivation Questionnaire

The motivation questionnaire was administers to all participants during the orientation session. The questionnaire lists various factors that might have influenced their decision to attend the institute. Participants were asked to rate on a 3 point scale ("1" indicating "Not at All Important"), "2" indicating "Somewhat Important", and "3" indicating "Very Important"). In addition they were asked to star those item that were of primary in their decision to attend. Those starred item were given a rating of "4".

Results of this questionnaire were analyzed across all participants and across all nineteen institutes. The highest means were the following items: " because I expect the information to be useful for my work and practice" (mean=2.90), "to better understand and work towards community problems" (2.89), "to become better informed about early childhood intervention in general", and "to become better informed about cultural sensitivity" (mean=2.86). The following items received the lowest means: "to get away from my job requirements and get recharged" (mean=1.59), "because my supervisor required it" (mean=1.61), and "because my supervisor recommended it" (mean=1.71). Although participants were required to have approval of their supervisor to attend the training, it was encouraging to see that this was not the primary reason they attended. These results also demonstrate and coincide with the principles of adult learning; principles which were embedded in this project. Information that is seen as a useful and relevant for the participant is a critical factor in training effectiveness.

Self-Rating Scale

The self-rating scale was developed specific to the institute and was based on competencies to be achieved during the training. The participants rated themselves pre and post training on 11 components according to how skilled they were presently and how skilled they would like to be. The results were analyzed by assigning a number value (1-5) to each level on the scale (1=unfamiliar, 2=awareness, 3=knowledge, 4=application, and 5=mastery).

Results were computed and analyzed to include all 19 institutes which completed self-rating scales. Institute number 8 did not complete this measure as it was being translated into Spanish. The results regarding how skilled participants were prior to training indicates that the majority of participants rated themselves at the level of unfamiliar (mean=1.84). On these same items, post and follow up institute measures indicate a significant change. Participants rated themselves at the level of knowledge (mean=3.24) and (mean=3.53, follow-up measures). Among the components that received the highest mean were "describe your program philosophy relating to child development, family involvement, delivery of services that are culturally sensitive, and interagency collaboration" (mean=3.59), "develop a protocol of useful strategies for culturally sensitive intervention" (mean=3.47), and 'include family members in service delivery that have authority in decision making, such as: grandparents, uncle, aunts, etc." (mean=3.43). See Appendix O for a further breakdown of individual institute self-rating scale results.

Consumer Satisfaction Questionnaire

At the last training session, the consumer satisfaction questionnaire was administered. Participants were asked to rate on a five point scale (1=strongly disagree to 5=strongly agree) their satisfaction with the content on the training, the presenters, the logistics, and the impact of the training. Each item was given a mean score as rated by the groups and then the means were computed for each item from each of the 19 institutes. The results indicate that the majority of the items were rated with scores of 4 or 5 demonstrating that the participants were satisfied with the institute. Items that received the highest scores were: "presenter knowledgeable" and" "presenter valued input" (mean=4.87), "relevant material" (mean=4.73), and "adequate illustrations" (mean=4.71). See Appendix O for consumer satisfaction charts from each institute.

Follow Up Consumer Satisfaction

At the last follow-up for task completion session, the follow-up consumer satisfaction was administered. Participants were asked to rate on a five point scale (1=strongly disagree to 5=strongly agree) course content, job relevance, individualized tasks, adequate support, ease of accomplishments, increase job performance, tasks well defined and training beneficial. All items were rated above 4. The following items were rated above 4.3: adequate support (4.49), course content (4.46), and training beneficial (4.43). Overall, all participants were satisfied with follow-up. See Appendix O for follow-up consumer satisfaction charts from each institute.

Task Completion

In order to better meet the needs of the institute participants, task requirements were continually reviewed and updated. For a complete description of the task requirements and percentage of tasks completed per institute, refer to Table 7. All institute participants were required to complete five tasks which where designed to reflect practical application of the training content. The tasks were modified accordingly to meet participants learning needs and practical application of training content. Changes were made so that more of the tasks would be completed during the training sessions. Especially for institutes conducted in Spanish, participants need that extra support and

NIÑOS ESPECIALES: A MODEL INTERVENTION PROJECT
FOLLOW UP/ TASK COMPLETION CHART
TABLE 7

INSTITUTE	# OF TASKS REQUIRED	RESOURCES & RESPONSIBILITIES	TIMELINE	%OF TASKS COMPLETED PER GROUP
I	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Due to high turnover, most participants did not complete their tasks.	Scheduled for 10/96	40%
II	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Due to high turnover, most participants did not complete their tasks.	Scheduled for 10/96	40%
III	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Due to high turnover, most participants did not complete their tasks.	Scheduled for 2/97	40%
IV	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Five participants of the original 9 completed the tasks.	F/U measures were completed by 11/97.	100%
V	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Eight participants of the original 13 completed the tasks. The 5 participants dropped out of the institute.	F/U measures were completed by 10/97.	100%

NIÑOS ESPECIALES: A MODEL INTERVENTION PROJECT
FOLLOW UP/ TASK COMPLETION CHART
TABLE 7

INSTITUTE	# OF TASKS REQUIRED	RESOURCES & RESPONSIBILITIES	TIMELINE	%OF TASKS COMPLETED PER GROUP
VI	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Nine participants of the original 15 completed the tasks. Four participants left the institute because they changed jobs. The last two didn't finish all the tasks.	F/U measures were completed by 10/97.	100%
VII	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	All follow up meetings for task completion were canceled at the last minute. Participants were from different programs. Some changed jobs.	Scheduled for 12/97	40%
VIII	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	Five participants of the original 10 completed the tasks. The other 5 left their jobs and couldn't commit to continuing the institute.	F/U measures were completed between 12/97 and 1/98.	100%
IX	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Three participants of the original 5 completed the tasks. The other two participants took different positions so they didn't want to continue with the institute.	F/U measures were completed between 12/97 and 1/98.	100%
X	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	Four participants of the original 5 completed the task.	F/U measures were completed by 2/98.	100%

NIÑOS ESPECIALES: A MODEL INTERVENTION PROJECT
FOLLOW UP/ TASK COMPLETION CHART
TABLE 7

INSTITUTE	# OF TASKS REQUIRED	RESOURCES & RESPONSIBILITIES	TIMELINE	%OF TASKS COMPLETED PER GROUP
XI	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	One participant of the original 5 completed the tasks.	F/U measures were completed by 2/98.	100%
XII	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	All participants were from the Welfare to Work program. Once they found full time jobs, they expressed desire to finish but never materialized.	Scheduled for 2/98	40%
XIII	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	Six participants of the original 10 completed the tasks.	F/U measures were completed by 2/98.	100%
XIV	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	Six participants of the original 6 completed the tasks. The other 3 participants dropped out of the institute.	F/U measures were completed by 3/98.	100%
XV	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	Participants were from the Welfare to Work Program. Participants found full time jobs, project staff was not able to contact them.	Scheduled for 9/98	40%

NIÑOS ESPECIALES: A MODEL INTERVENTION PROJECT
FOLLOW UP/ TASK COMPLETION CHART
TABLE 7

INSTITUTE	# OF TASKS REQUIRED	RESOURCES & RESPONSIBILITIES	TIMELINE	%OF TASKS COMPLETED PER GROUP
XVI	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Team Meeting	All four participants left the field of early childhood for different reasons.	Scheduled for 12/98	40%
XVII	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	All participants were from the Welfare to Work program. Once they found full time jobs, they expressed desire to finish but never materialized.	Scheduled for 6/99	40%
XVIII	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	Five participants of the original 17 completed all the tasks. One participant dropped out due to family reasons and the rest haven't finished all the tasks.	F/U measures were completed by 6/99.	100%
XIX	Program Philosophy Cultural Sensitive Protocol Family Interview of a different culture IEP or IFSP Extend services into the community	Five participants of the original 10 completed all the tasks. Three participants dropped out due to family reasons. The remaining two haven't completed all the tasks.	F/U measures were completed by 8/99.	100%

guidance to complete tasks. After completion of all the tasks and evaluation measures, participants received a Certificate of Completion. From Table 7, shows that 11 out of 19 institutes completed all of the assigned tasks. The 8 institutes were not able to complete tasks for different reasons. Within these programs, there was a high turnover of staff, constant changes in responsibilities, and for the participants in the Welfare to Work Program, once they found full time employment they were not available to do follow-up and complete tasks. See Appendix O for samples of tasks and task completion checklists that were completed for individual institutes.

Replication

The training replication with Waterbury Youth Services, POWER program, was completed in September 1999. All training components were implemented and trainer received guidance, support and technical assistance throughout replication. See Appendix Q for a copy of the training replication schedule.

A Training Session Evaluation form was developed to assist participant in organizing information about the group characteristics and process of the training. A Trainer Evaluation Form was developed for project staff to fill out after observing the participant, reflecting on preparation of the participants, use of activities, etc. and identifying areas where the participant needed guidance, support and technical assistance. The information of this form and the Trainer Evaluation form were used at the debriefing meeting to analyze the training session and provide technical assistance to participant. See Appendix P for a copy of the Training Session Evaluation and Trainer Evaluation Form and see Appendix R for a copy of the Technical Assistance Summary.

Individual results for institutes I-XIX with regard to specific demographic, motivational, self-rating, and consumer satisfaction information is included in the following text. As mentioned before, the corresponding charts for each institute are in Appendix O.

Demographic Results per Institute

Institute I & II consisted of two groups that met Wednesday morning and afternoon. Each group had 11 to 13 participants totaling 24 all together; 1 social worker, 1 family service coordinator and 22 family service workers.

They ranged in years of experience working with the birth to five population from a low of less than a year to a high of 15 years and with a mean of 5 years. Two participants did not answer this question.

Nine participants had a High School Diploma as the highest degree earned; one had an Associates degree; twelve had a Bachelor degree; and two had Masters degrees in Social Work and Education respectively.

Supervision and Mentorship

Supervision and Mentorship

I. Background

Fenichel and Eggbeer (1990) identified four elements as essential to fostering competence in the provision of services to infants and toddlers and their families. These are:

- A knowledge base that spans all disciplines concerned with infants and toddlers
- Adequate opportunities for observation and interaction with children and their families
- Individualized **supervision** that allows for reflection upon all aspects of a practitioner's work with children, families, and colleagues across all disciplines
- **Collegial support**, beginning early and continuing throughout one's professional career, both within and across disciplines

All four of these elements need to be present throughout the professional life of a practitioner, and the opportunity for all four to occur regularly must be built into any successful early intervention program. A **supervision and mentorship program** might include all of these elements, as supervisors and mentors would be experienced in the essential core concepts of the knowledge base, would provide opportunities for observation and interaction with families, reflection as part of the relationship, and ongoing collegial support.

Supervision and mentorship share many of the same qualities. When both relationships are discussed in this text, the supervisor and mentor will be known as the facilitator, while the supervisee and mentee will be known as the participant.

Benefits

A traditional supervision or mentor relationship involves two people, and the relationship provides benefits to both. In this relationship, both parties experience an increase in self-awareness, as well as personal and professional growth. As they share feelings, reflections, opinions and personal goals, they examine each of these in the context of the other's experience, providing new perspectives for both. The participant is helped to develop problem-solving skills, while the facilitator refines his/hers. The participant acquires new knowledge, and the facilitator experiences the refinement and new applications and viewpoints of his/her knowledge. The participant develops a better theoretical foundation, while the facilitator has the opportunity to hone his/her teaching skills. Through the facilitator's professional contacts, the participant can increase his/her own professional network, and may have opportunities to develop his/her leadership abilities. The facilitator develops political strategies while assisting the participant in moving among professional colleagues, and both benefit from the team building approaches that such networking affords. The participant receives support for his/her own career goals and affirmation of his/her professional skills, while the facilitator benefits from the opportunity to nurture and support the creativity and professional development of another person.

Elements of an Effective Supervisory/Mentorship Program

Fenichel (1992) states that there are three elements that are essential to an effective supervisory/mentorship program:

- reflection,
- collaboration, and
- regularity

A fish has no concept of water until it is removed from the water. Then, suddenly, it knows at some level that there is a difference between "water" and "no water." In the same way, reflection enables us to remove ourselves from a situation enough to look objectively at that situation; to examine it from each person's unique perspective, to look at the events that occurred and the practitioner's feelings about those events. The process of reflection includes such questions as, "What were you thinking about when you did that? The facilitator can help the participant to look at the situation in terms of his/her own life experience, to see how earlier events in his/her life have shaped his/her values, opinions, and priorities, and how these affect his/her behavior in current situations. The facilitator may ask the participant to suggest alternate ways of handling a situation and to examine his/her feelings about those alternate suggestions. By so doing, the participant may decide to use a different strategy the next time that situation presents itself. The facilitator might suggest readings or professional observations of other practitioners to generate alternative ideas about how to handle specific situations. Role playing might also be used as a way to practice newly discovered behavioral responses. Reflection may result in an increased tolerance for ambiguity, and a sense of what it means to go beyond doing what comes naturally with an infant. Participants learn to question conventional wisdom, and to develop their own decision-making abilities.

Cognitive Supervision (Garmston, 1989) allows for the participant to evaluate his/her own competence; judging both positive points and areas in which there is need for improvement. The facilitator in this instance acts as a supporter for the participant's reflection.

Collaboration has been described as being "like having a friend on a difficult journey," and involves three components:

- power,
- mutual expectations, and
- communication

Power is derived from knowledge and access to resources. In both relationships, the power is shared. In the supervisory relationship, the supervisor has the academic or clinical experience and the supervisee has the work and life experiences. The supervisor may have the responsibility of evaluating growth, but through the reflection process the supervisee is encouraged to practice ongoing self-evaluation. In the mentoring relationship, since the mentor and mentee have distinct academic, work and life experiences to contribute, power may flip back and forth in the service of goal attainment.

Expectations of both parties must be articulated at the beginning of the relationship, and need to be constantly evaluated and re-negotiated throughout the relationship. Goals and responsibilities of the participant should be stated. Trust and respect of the parties for each other are essential ingredients of this process. This kind of open communication between facilitator and participant sets a standard for future professional relationships among practitioners and between practitioners and families. Issues for collaboration may include on-the-job performance, written notes of interactions, verbal accounts of the participant's experiences, reflection of the facilitative relationship, and the experience of the facilitator.

Reflection and collaboration must occur on a regular basis in order to be effective. The development of trust that facilitates the processes of reflection and easy collaboration takes time and effort. It is this time that is the most difficult element of the supervisory/mentorship relationship for many practitioners. The size of the caseloads and the limited amount of time available for the provision of service, paperwork and other administrative details of the job decreases the amount of time available for supervision and mentorship. The supervisory/mentor relationship provides strategies for long-term stress management, time management, professional development, collegiality, and career advancement.

Bertacchi (1996) addressed the emotional, as well as the intellectual, engagement of professionals to families in early intervention. Examining reactions and feelings towards families and other professionals in an open communication with a facilitator will positively influence the success of the participant as an early interventionist.

In many organizations, professional development of this kind is seen as a luxury, rather than a necessity; and there are many barriers that can prevent the development of a first-rate supervisory/mentor program.

Barriers

The time needed to develop and maintain the type of relationship necessary for successful supervision or mentorship is one of the costs and potential barriers to the development of such a program. The supervisory/mentor relationship may endure for months or years, and the facilitator and participant need to set aside time to meet on a regular schedule. Time spent this way is therefore unavailable for other activities of a personal or professional nature, and therefore choices must be made by both facilitator and participant about the relative importance of the supervisory/mentor process to each party in light of other opportunities. Many professionals recognize the positive effects of such a relationship, but don't see it as important enough to be a part of the work day. Rather, it must be something done on their own time, at their own expense.

For the participant, the supervision/mentor relationship may result in some uncomfortable realizations, and the pressure to change strategies may present a stressful situation. Dealing with the stress, of course, will provide a growth experience, as well as the flexibility to develop new skills, but the discomfort of the need to change may be a deterrent to some to enter into this type of relationship. Also, the need to be completely honest with one's feelings may engender a fear of censure for feelings or opinions that may be deemed unacceptable or inappropriate by the facilitator. Because the rewards of the relationship are primarily intangible, both the facilitator and participant must evaluate carefully their commitment to the supervisory/mentorship concept and the benefits they hope to gain.

It is also a necessity that the philosophy of the practitioner's organization embrace the concept of mentorship and supervision, so that the appropriate resources can be allocated to the programs.

Supervision and mentorship

The terms supervision and mentorship are often used interchangeably. Robertson (1992) distinguishes between mentoring and supervision. She points out that supervision is usually tied to the goals and needs of the organization, and the supervisor has a responsibility to shape the supervisee's behavior to meet those needs and goals. Supervision embraces and reflects the philosophy and structure of the organization, and the purpose of supervision is to bring the supervisee in line with that structure and to provide service within that philosophical framework. The purpose of a supervisory relationship is to help the supervisee learn how to be his/her best professional self, in order to provide the best possible service. The most accomplished supervisors create an environment where the participant can feel secure enough to expose their weaknesses, mistakes, questions, and differences. This supervisory relationship must be invested in on both sides.

Mentoring, on the other hand, is defined as a relationship in which "one person is dedicated to the personal and professional growth of the other." Its main purpose is professional instruction and guidance. Mentor and mentee exchange opinions, discuss activities and feelings related to those activities, share problem-solving and decision-making strategies, and build communication skills and evaluation strategies. The mentoring relationship has among its goals the sharing of knowledge, skills, attitudes, feelings, and aspirations within a framework of established goals and professional culture. Acting in a supportive role, the mentor assumes authority only when the mentee gives it to him/her, and the responsibility for the final product rests with the mentee (Kagan, 1991).

Fenichel (1992) reports that in focus groups conducted by ZERO TO THREE, practitioners described supervision as a more professional relationship, while mentorship was more personal, and also more voluntary. **A supervisor could be a mentor**.

The supervision and mentor relationships that you are about to enter into are a combination of the two models defined above. Since one of your supervisors for this program is your agency supervisor, the organizational and job advancement aspects of this role may apply. On the other hand, as professionals dedicated to following best practices when working with infants and toddlers with disabilities and their families, this supervisory role for both your agency and program supervisors will have similar characteristics of the mentorship model of professional development. You will also begin a more typical mentor relationship with a colleague. All facilitators (supervisors and mentors) will be available to guide you through the process of obtaining your personal goals and the required tasks, as well as a source for obtaining the additional resources you may need to increase your competence and confidence in providing early intervention services to families.

Peer Mentorship

The lack of available and interested "experts" to serve as mentors can be another deterrent. In that situation, peer mentorship provides a workable solution, particularly in small organizations in which there is a multidisciplinary staff (Fenichel, 1992). In a peer mentorship relationship, there is no perceived "expert." Both or all parties expect to learn from each other and to benefit from their respective life experiences as they share attitudes, feelings, opinions, strategies, information and insights. In a multidisciplinary setting, this provides a rich mix of experiences, and the opportunity for cross-disciplinary sharing that may provide benefits that differ from those in a more traditional mentoring relationship that occurs within a discipline.

In any peer mentorship program, the attitude of the participants is important. They need to be willing participants and to enter the program with the assurance that they have something to contribute as well as something to learn from others. Developing an atmosphere of trust and respect is the first step in this process.

II. Your Responsibility

Supervision

In order for the supervisory relationship to work, the supervisee must be involved in:

- developing the learning structure to which s/he will be exposed
- develop a contract or an agenda defining expectations
- analyzing his/her own work
- contributing to the evaluation of his/her own work

In doing this, the supervisee is better able to contribute to his/her own learning. The supervisee is also responsible for making observations about his/her own work and reporting these observations to the supervisor. When the supervisee takes this active role in the process of learning, the relationship between the supervisee and supervisor becomes very open, allowing both the supervisor and supervisee to grow in their individual roles.

Characteristics of the Supervisee

In order to develop this collaborative relationship, there are certain characteristics the supervisee should have. These characteristics are also shared by the supervisor. The extent to which the supervisor and supervisee are able to portray these characteristics is the extent to which the collaborative relationship will succeed. Read the following list of characteristics, and ask yourself to what extent do these apply to me:

- The capacity for intimacy and self-disclosure
- The willingness to learn
- The confidence to try new things
- A genuine interest in self development
- A belief in the capability of others
- Good communication skills including listening
- Trust
- A responsive openness and availability
- The ambition to succeed and to learn

- An internal locus of control
- Sensitivity
- High investment in your job
- Willingness to commit to a relationship
- Places a high value on relationships
- Sees a relationship between personal and professional growth
- Able to sustain a close, personal relationship
- Understands others
- Is an active learner
- Is objective, open-minded and flexible
- Is direct, constant, focused
- Thinks clearly
- Is able to confront and accept

Goal setting is critical to the success of the process. The supervisor must clearly understand exactly what you want to get out of this relationship.

Characteristics of a Supervisor

A supervisor can be thought of as a coach, providing his/her knowledge and experience from which the supervisee can learn. Good coaches in sports:

- Allow athletes to set their own goals
- Break complex skills down into small units
- Provide a model
- Allow for simple guided practice with feedback
- Encourage independent practice
- Praise and reward athletes when they win
- Support and reassure athletes

(McREL, 1984-85)

Supervisors in any situation can utilize these qualities to provide the same opportunities for supervisees.

In addition, a good supervisor encourages and models respect and sensitivity to all families with whom s/he interacts. A supervisor must use keen observational skills and be credible to the supervisee. As stated previously, the supervisor will have core knowledge of early intervention best practices. In specific areas where the supervisor may not feel comfortable, s/he should be knowledgeable of the available resources to acquire that knowledge. Innate qualities central to a good supervisor is integrity and honesty, and the commitment to monitor quality and understand the competencies of the supervisee.

In cognitive supervision (Garmston, 1989), the role of the supervisor is to facilitate the participant's analysis of their performance. Specific open-ended questions that can be used for eliciting information are: "How did you do at meeting your objectives?", "What data supports your line of thinking?", "What do you think the problem is?" How can you find out if that is in fact the issue?"

Mentorship

Robinson (1992) states that the following elements are essential for the success of any mentoring program:

- There must be a good personality fit between mentor and mentee
- Mentor and mentee must take sufficient time together for planning, participation and reflection
- The mentee must be motivated
- Goals of both mentor and mentee must be clearly articulated
- The relationship must include shared trust and respect

As you choose the other students with whom you will mentor, keep these elements in mind. Who in the class would you like to spend an extensive amount of time with over the next few weeks? What is it that you want to take away from this relationship, and what do you have to offer to others? Who are the one or two people you think you can build a trusting relationship with? As you develop trust and confidence in the process, you will be able to more clearly see yourselves as givers as well as takers in this process, and will begin to develop your own leadership abilities.

Selecting a Peer Mentor

Robinson (1992) suggests that practitioners do the following to select a mentor:

- Identify the characteristics you bring to the relationship

- List the characteristics you seek in a mentor
- Identify several potential mentors
- Summarize what you hope to accomplish
- Describe what you are willing to commit

Looking at your own strengths and at what you want to accomplish in a mentoring relationship will help to create a good fit between mentor and mentee, and since, in a peer mentorship relationship, each party takes on both roles at various times, it is very important to determine at the beginning what each of you brings to the table, and what each hopes to gain from the relationship. To begin this process, Robinson (1992) suggests that you each define your current roles and strengths, then define the roles you would like to have and the strengths you would need to develop in order to successfully meet the requirements of those roles.

Characteristics of Peer Mentors

As peer mentors you, will be both teachers and learners in the process. The following characteristics of mentors and mentees are similar to those of supervisees :

- The ability to provide a broad view and a vision
- The potential to succeed
- The willingness to provide support and counsel
- The capacity for intimacy and self-disclosure
- Access to professional networks and the willingness to share this access
- The willingness to learn
- Leadership experiences
- The confidence to try new things
- Political awareness
- A sense of self-worth and the ability to convey this to others
- A genuine interest in the development of others
- A belief in the capability of others
- Good communication and teaching skills
- Trust
- A responsive openness and availability

- The ambition to succeed and to learn
- Competency, authenticity
- An internal locus of control
- Sensitivity
- High investment in your job
- The ability to motivate others
- Strong moral fiber
- Willingness to commit to a relationship
- Places a high value on relationships
- Sees a relationship between personal and professional growth
- Able to sustain a close, personal relationship
- Understands others
- Is an active learner
- Is objective, open-minded and flexible
- Is direct, constant, focused
- Thinks clearly
- Is able to confront and accept

As your relationship progresses, power shifts will occur often, as one or the other of you takes over and shares your resources. Goal setting is critical to the success of the process. Each of you must know what the other(s) want(s) to accomplish within the relationship.

Adult Learning Theory

This model of supervision and mentorship is based on adult learning theory. As participants, you can benefit from an understanding of adult learning theory, which states that adults learn best when they are actively involved in the learning process, and when a variety of techniques are used in the instructional process. There are physical, emotional, and intellectual factors to take into account. Adults learn when they are motivated to do so by situations or circumstances in their lives which they need to address. Also, adult learners:

- want to be self-directed
- need to know why information is important
- come with prior knowledge and experience
- are life, task, and problem centered

- want to participate in assessing their own needs and selecting goals
- want real work applications and examples
- retain what is relevant to their situation
- want accurate feedback on their progress toward their goals
- can solve problems creatively

By discussing these factors with your facilitator, you can structure the learning environment and tailor the tasks to fit your needs.

Building and Structuring the Relationship

You will need to spend time getting to know each other so that you can set goals together and make sure that each of your needs are being met. Different life experiences and circumstances, learning styles, professional backgrounds, expectations and problem-solving strategies will enrich the relationship and expand the possibilities for learning. Each of you must be open to what the other(s) has/have to offer, and there must be a healthy respect for differences in style and background. Each of you must understand the developmental stage of the others, and each must be willing to take the role of both teacher and learner at any given time in the relationship.

Providing a structure that is comfortable for everyone is essential in order to maximize the time spent together. Work to create an environment in which the free exchange of information can take place. The environment must feel safe to both of you, and you need to plan sufficient time so that no one will feel rushed and both of you will feel as though you have sufficient access to each other. Robinson (1992) also suggests that provisions be made for the celebration of milestones within the relationship; to acknowledge new learning, the application of new strategies to recurring problems, and other signs of developmental progress.

All members will benefit from the relationships you form, and these benefits will translate into improved practical skills, early intervention expertise and career advancement, as well as continuously improving your profession. As you develop your leadership skills through the supervisory/mentorship process, you will integrate these skills into all of your work and to positions of increasing responsibility and authority. Many of the competency requirements demand knowledge across disciplines and, therefore a broader repertoire of skills. To accomplish these competencies, supervision and mentorship must occur in an atmosphere of safety and personal and professional growth. As more people enter into these types of relationships, the power base of your professions will be broadened. As you and other practitioners interface with each other across disciplines, more opportunities for professional development will present themselves, and the health and education communities at large will benefit. Finally, all of you can model and foster collaboration among families, providers, administrators and policymakers, thereby impacting communities throughout the country in the provision of services to infants and toddlers.

Responsibilities of Supervisor vs. Peer Mentor

Supervisor	Mentor
1. Monitors and evaluates	1. Observes and supports
2. Supports strengths	2. Provides positive feedback
3. Facilitates problem solving	3. Assists in problem solving
4. Relates theory and practice	4. Reflects on current practice
5. Shares experiences and expertise	5. Shares experiences and expertise
6. Considers alternative strategies	6. Provides alternative strategies
7. Expands, refines and builds teaching skills	7. Expands, refines and builds practitioner skills

III. The Supervision/Mentor Process

For each Early Intervention Specialist Program participant, the practicum plan of supervision and mentorship will look different, based on the needs, experience and comfort level of each participant. In partnership with your agency supervisor, you will design a contract that integrates both supervision and mentorship (attached). No matter how the contract is designed the process of supervision or mentorship will include the Preconference to design strategies for implementing the competency/observation; the actual observation or achievement of the competency; and feedback during the Postconference. All supervision/ mentor experiences should encompass the following format:

Preconference (can occur via phone, fax, e-mail or in person):

⇒ Participant will identify the nature of the competency.
⇒ Participant will state the objectives to be met.
⇒ Participant and facilitator will discuss what will occur.
⇒ Participant and facilitator will predict what the family/child will do.
⇒ Participant and facilitator will consider problems with the plan.
⇒ Participant and facilitator will select appropriate observational techniques.

(Adapted from: Emrick, W. 1989)

Observation of participant based on Preconference decisions

Postconference:

⇒ Participant will review his/her observations of the child and family during the visit.
⇒ Participant, with facilitator support, will compare the actual visit to the outlined plan.
⇒ Participant, with facilitator support, will examine possible influences the participant had on the situation.
⇒ Participant and facilitator will look at the data from both recorded during the observation.
⇒ Participant and facilitator will explore the attainment of objectives.
⇒ Participant and facilitator will explore what the participant would do the same and different on the next opportunity.

(Adapted from: Emrick, W. 1989)

IV. Evaluation

As part of the Early Intervention Specialist Program, each of you agreed to participate in a total of 900 supervisory/peer mentorship hours. Your contract is individualized to meet yours and your agency supervisor's needs. The contract should specify the time that will be spent working under the leadership of your agency and the program supervisor, as well as the time with a peer mentor, to delineate goals and objectives for achieving the competencies. The supervision/mentorship process (Preconference, Observation, Postconference) will be recorded on the Action Plan (attached). It is required that supervision and mentorship with one of your facilitators occurs biweekly. For participants who are primarily using a peer mentorship model, you are required to meet with one of your **supervisors** at least monthly.

For the peer mentor relationship, this does not necessarily mean that you and your partner(s) will have the same goals and objectives, or will be working on the same competencies at the same time. In a peer relationship, you can work together to achieve the same goals, or you can use each other as "expert" resources while working on different competencies.

Preconferences, observations and postconferences will be recorded by completing the attached Contact Logs. Every contact, whether it is one of your supervisors, your peer mentor, others in the field, or on your own doing research, should be noted on these logs. **A copy of these logs must be given to the program coordinator monthly. Each participant will be responsible for defining, documenting, and carrying out the competencies they need to complete.** The program coordinator will assist the participants with setting up all requested resources and approving substitute tasks.

You will also be required to submit **weekly practicum logs** using the format provided. These log sheets should be as detailed as possible, including a reflection on what you learned for that week.

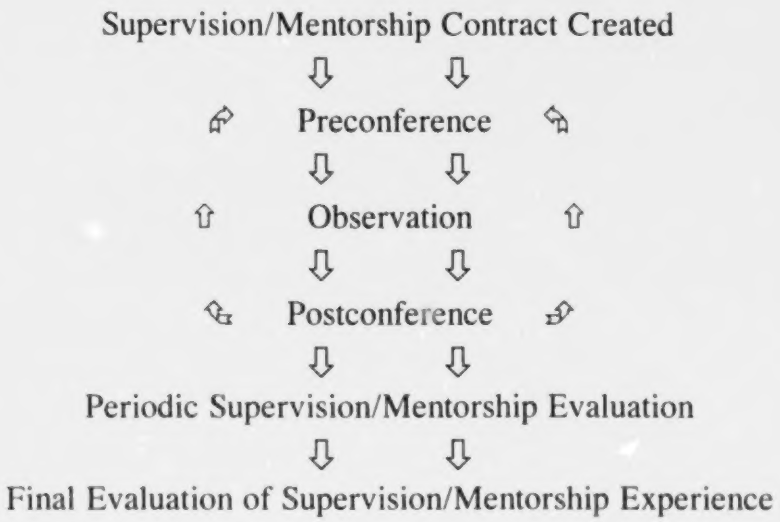
Your performance on the stated competency will be rated on several facets of the competency by your observing facilitator, using a six point likert scale. There is also space to discuss qualitative aspects. These evaluations will be used as both a starting point for the Postconference discussion, as well as credit for achieving the stated competency.

Peer Mentors will also fill out the **Peer Mentorship Postconference Support Sheet** in preparation of the Postconference.

The paperwork associated with each step of the supervisory/mentorship process is summarized in the chart below:

When	Who	Form	What to do
Weekly	Participant	Practicum Log	Hand in monthly
Any contact	Participant	Contact Log	Hand in monthly
Preconference	Participant/ Facilitator	Action Plan	Explain objectives & plan with facilitator
Observation	Facilitator	Competency Checklist	Observe & rate performance on form; copy for facilitator, participant; program coordinator
Postconference	Facilitator/ Participant	Action Plan & Peer Mentorship Postconference Support Sheet (completed prior to conference)	Action Plan - Identify progress made & future plans; Support Sheet -Identify strengths, questions & facilitation strategies; Copy for facilitator, participant; program coordinator

The supervisory/mentorship experience is summarized in the following diagram:


Supervision/Mentorship Contract Created
Preconference
Observation
Postconference
Periodic Supervision/Mentorship Evaluation
Final Evaluation of Supervision/Mentorship Experience

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Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Family Assessment
1

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Assessment

1. When introducing an assessment tool, explains fully how the information will be used and why it is important	1	2	3	4	5	6
2. Matches the assessment tool to family needs	1	2	3	4	5	6
3. Structures the assessment and information gathering process to support the family and clarify their goals	1	2	3	4	5	6
4. Conducts the assessment as a process to foster respect and family empowerment	1	2	3	4	5	6
5. Respects family lifestyle and rhythms	1	2	3	4	5	6
6. Uses the information from the assessment to generate resources, priorities and concerns to meet family goals	1	2	3	4	5	6
7. Uses the IFSP to meet the needs identified by the family	1	2	3	4	5	6
8. Shares written notes with the family	1	2	3	4	5	6
9. Monitors changes in family resources, priorities and concerns	1	2	3	4	5	6

Communication

10. Matches nonverbal communication (facial expression, posture, physical proximity) to context	1	2	3	4	5	6
11. Matches nonverbal communication to verbal communication	1	2	3	4	5	6
12. Demonstrates active listening	1	2	3	4	5	6

(Continued on back)

13. Uses minimal encouragers or verbal following to clarify or expand family's information	1	2	3	4	5	6
14. Predominantly uses open ended questions	1	2	3	4	5	6
15. Rephrases questions and asks for examples to ensure family understanding	1	2	3	4	5	6
16. Clarifies family input through the use of paraphrasing	1	2	3	4	5	6
17. Uses effective reflection of feelings	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Family Interview
2 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:
6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Interview

1. Explains the purpose of the interview	1	2	3	4	5	6
2. Discusses confidentiality	1	2	3	4	5	6
3. Structures the physical environment	1	2	3	4	5	6
4. Conducts interview as a process to foster respect and family empowerment	1	2	3	4	5	6
5. Respects family lifestyle and rhythms	1	2	3	4	5	6
6. Allows the parents to do most of the talking	1	2	3	4	5	6
7. Explores family priorities, resources and concerns	1	2	3	4	5	6
8. Shares written notes with family	1	2	3	4	5	6
9. Uses the IFSP to meet the needs identified by the family	1	2	3	4	5	6
10. Provides closure by thanking family for contributions and restates objectives for the next meeting	1	2	3	4	5	6

Communication

11. Matches nonverbal communication (facial expression, posture, physical proximity) to context	1	2	3	4	5	6
12. Matches nonverbal communication to verbal communication	1	2	3	4	5	6
13. Demonstrates active listening	1	2	3	4	5	6
14. Uses minimal encouragers or verbal following to clarify or expand family's information	1	2	3	4	5	6

(Continued on back)

15. Predominantly uses open ended questions	1	2	3	4	5	6
16. Clarifies family input through the use of paraphrasing	1	2	3	4	5	6
17. Uses effective reflection of feelings	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Interviewing Family of Cultural Minority
3

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Interview

1. Explains the purpose of the interview	1	2	3	4	5	6
2. Discusses confidentiality	1	2	3	4	5	6
3. Establishes rapport with family for communication	1	2	3	4	5	6
4. Respects family lifestyle and rhythm	1	2	3	4	5	6
5. Allows the parents to do most of the talking	1	2	3	4	5	6
6. Discusses rationale for family's migration/immigration	1	2	3	4	5	6
7. Explores family priorities, resources and concerns	1	2	3	4	5	6
8. Explores concerns family may still need	1	2	3	4	5	6
9. Identifies adaptations for culturally sensitive intervention	1	2	3	4	5	6
10. Shares written notes with the family	1	2	3	4	5	6
11. Provides closure by thanking family for contributions and restates objectives for the next meeting	1	2	3	4	5	6
12. Overall conducts self in culturally respectful manner	1	2	3	4	5	6

Communication

13. Matches nonverbal communication (facial expression, posture, physical proximity) to context	1	2	3	4	5	6
14. Matches nonverbal communication to verbal communication	1	2	3	4	5	6
15. Demonstrates active listening	1	2	3	4	5	6

(Continued on back)

16. Uses minimal encouragers or verbal following to clarify or expand family's information	1	2	3	4	5	6
17. Clarifies family input through the use of paraphrasing	1	2	3	4	5	6
18. Uses effective reflection of feelings	1	2	3	4	5	6
19. Talks in simple language family can understand	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Family Checklist
Child Care
4

Participant: ______________________________ Date: ______________________________

Family Rater: ______________________________ Setting: ______________________________

The purpose of the child care task is to give the participants a sense of daily life with a child with a disability. Please rate the participant's performance on each of the following statements. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Discussed sufficiently with you the typical daily routine and care for your child 1 2 3 4 5 6

2. Carried out the typical daily routine in caring for your child 1 2 3 4 5 6

3. Ensured the safety and well being of your child 1 2 3 4 5 6

4. Soothed your child when s/he became upset 1 2 3 4 5 6

5. Any comments you would like to make about the participant's performance?

6. Any comments you would like to make about this assignment?

I certify that ______________ has successfully completed a total of six (6) hours of child care for my family on
participant's name

the following dates and number of hours per visit.

Date	# of hr.

____
Parent's Signature/Date

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Parent-Child Assessment
5

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Explains the purpose of the assessment	1	2	3	4	5	6
2. Explains fully how the assessment will be used	1	2	3	4	5	6
3. Promotes natural circumstances for assessment	1	2	3	4	5	6
4. Conducts the assessment as a process to encourage the family's capacity for interaction	1	2	3	4	5	6
5. Adapts the assessment to the individual family	1	2	3	4	5	6
6. Emphasizes strengths in the current interaction	1	2	3	4	5	6
7. Respects family lifestyle and rhythms	1	2	3	4	5	6
8. Rephrases questions and asks for examples to ensure family understanding	1	2	3	4	5	6
9. Accepts and incorporates multiple data sources on interaction	1	2	3	4	5	6
10. Conducts assessment using a natural framework that blends testing and teaching alternative interaction strategies	1	2	3	4	5	6
11. Communicates recommendations and rationale in an understandable manner	1	2	3	4	5	6
12. Communicates recommendations sensitively	1	2	3	4	5	6
13. Integrates recommendations into IFSP	1	2	3	4	5	6
14. Develops intervention based on the developmental level and interactional competence of the parent	1	2	3	4	5	6
15. Provides families with a sense of accomplishment	1	2	3	4	5	6

Please use the space on the back to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Child Assessment Selection
6

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Assessment Decision: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Appropriately identifies purpose of assessment tool	1	2	3	4	5	6
2. Determines multiple information gathering techniques for assessment	1	2	3	4	5	6
3. Identifies specific instruments to be used in assessment	1	2	3	4	5	6
4. Examines pyschometric properties of assessment instrument	1	2	3	4	5	6
5. Examines developmental appropriateness of skills in assessment instrument	1	2	3	4	5	6
6. Identifies procedures for each assessment tool	1	2	3	4	5	6
7. Concludes limitations of each assessment tool	1	2	3	4	5	6
8. Concludes limitations of assessment procedure and subsequent decision	1	2	3	4	5	6
9. Utilizes assessment techniques that result in applicable decision making	1	2	3	4	5	6
10. Communicates effectively to family the above findings	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Child Developmental Assessment
7

Participant: ______________________________ Date: ____________________________

Supervisor/Mentor: ____________________________ Setting: __________________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Explains clearly the purpose of the assessment	1	2	3	4	5	6
2. Gives the family a choice in their level of participation	1	2	3	4	5	6
3. Explains fully how the assessment will be used and why	1	2	3	4	5	6
4. Promotes natural circumstances for assessment	1	2	3	4	5	6
5. Conducts the assessment as a process to empower the family's capacity to enhance their child's development	1	2	3	4	5	6
6. Adapts the assessment to the individual child and family	1	2	3	4	5	6
7. Emphasizes the child's strengths in the assessment process	1	2	3	4	5	6
8. Rephrases questions and ask for examples to ensure family understanding	1	2	3	4	5	6
9. Accepts and incorporates multiple data sources	1	2	3	4	5	6
10. Conducts assessment using a natural framework for child	1	2	3	4	5	6
11. Conducts assessment using a natural framework for family's understanding	1	2	3	4	5	6
12. Communicates recommendations sensitively and in an understandable manner	1	2	3	4	5	6
13. Interprets assessment information appropriately	1	2	3	4	5	6
14. Integrates recommendations into IFSP	1	2	3	4	5	6

(Continued on back)

15. Provides opportunities to consult with staff on strategies to implement recommendations	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
IFSP Family Outcomes and Objectives
8

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Communicates clearly the Birth to Three family-centered philosophy	1	2	3	4	5	6
2. Uses multiple strategies to elicit outcomes from the family	1	2	3	4	5	6
3. Facilitates the entire team to identify strategies for accomplishment of family outcomes	1	2	3	4	5	6
4. Uses multiple strategies to have family identify resources for accomplishment of outcomes	1	2	3	4	5	6
5. Spends more time on family vs. interventionist's agenda	1	2	3	4	5	6
6. Bases outcomes from family assessment/interview	1	2	3	4	5	6
7. Provides options for achieving outcomes consistent with the family system	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Individual Family Service Plan
9

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

General						
1. Summarizes the infant/toddler's level of development in integrated terms and is jargon free	1	2	3	4	5	6
2. Explores the family's resources, priorities and concerns	1	2	3	4	5	6
3. Develops outcomes based specifically from the family's concerns	1	2	3	4	5	6
Child Objectives						
4. Writes objectives in developmentally sequenced order	1	2	3	4	5	6
5. Has dates for accomplishment in chronological order	1	2	3	4	5	6
6. Writes objectives that are a developmental subskill of the outcome	1	2	3	4	5	6
7. Identifies ways to write objectives to include the family	1	2	3	4	5	6
8. Produces objectives that are functional, general, and can be taught in daily environments	1	2	3	4	5	6
9. Includes a performance criteria in the objective	1	2	3	4	5	6
10. Writes objectives operationally	1	2	3	4	5	6

(Continued on back)

Family Objectives

11. Writes out plan for family to and early interventionists to follow	1	2	3	4	5	6
12. Empowers, not enables, family to achieve objectives	1	2	3	4	5	6
13. Writes operational objectives that are respectful of parents as adults	1	2	3	4	5	6

Services

14. Identifies specific services including method, interventionist(s), frequency and intensity of services	1	2	3	4	5	6
15. Projects dates for initiation of services	1	2	3	4	5	6
16. Sets up a transition plan into receiving program	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Facilitation of IFSP or Team Staffing Conference
10

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Prepares a flexible agenda to be followed at the meeting	1	2	3	4	5	6
2. Begins meeting by stating philosophy, agenda and objectives	1	2	3	4	5	6
3. Ensures each participant has an opportunity for input	1	2	3	4	5	6
4. Ensures family speaks first and often	1	2	3	4	5	6
5. Ensures meeting centers around the family's priorities	1	2	3	4	5	6
6. Mediates any team differences	1	2	3	4	5	6
7. Written summary of meeting identifies impact of team dynamics	1	2	3	4	5	6
8. Written summary identifies how different team dynamics could change outcome of meeting	1	2	3	4	5	6

Please use the space below to provide any comments or cites specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Family Service Delivery
11

Participant: ______________________________ Date: ____________________________

Supervisor/Mentor: ______________________________ Setting: __________________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Respects family life style and rhythms	1	2	3	4	5	6
2. Spends most of the time on the family's vs. the interventionist's agenda	1	2	3	4	5	6
3. Prepares a flexible agenda	1	2	3	4	5	6
4. Prepares materials, data collection strategy, & methods	1	2	3	4	5	6
5. Provides a rationale for suggestions to the family	1	2	3	4	5	6
6. Uses appropriate language for explanation	1	2	3	4	5	6
7. Communicates effectively with parents	1	2	3	4	5	6
8. Utilizes adult learning principles in intervention	1	2	3	4	5	6
9. Builds a collaboration with the family	1	2	3	4	5	6
10. Empowers family by supporting their roles, functions and networks, not by supplanting natural resources	1	2	3	4	5	6
11. Adapts level of assistance to meeting individual family priorities	1	2	3	4	5	6
12. Ensures family understands each team member's roles (including the family's) and responsibilities	1	2	3	4	5	6
13. Identifies options for a family to make informed decisions	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Evaluation Checklist
Curriculum Evaluation
12

Participant: ______________________________ Date: ______________________________

Supervisor/Mentor: ______________________________ Curriculum: ________________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Identifies basic information from curriculum	1	2	3	4	5	6
2. Evaluates psychometric properties of curriculum	1	2	3	4	5	6
3. Researches and evaluates scope of curriculum	1	2	3	4	5	6
4. Evaluates format of curriculum	1	2	3	4	5	6
5. Evaluates use of behavioral objectives in the curriculum	1	2	3	4	5	6
6. Evaluates degree of task analysis	1	2	3	4	5	6
7. Evaluates functional adaptations available	1	2	3	4	5	6
8. Evaluates use as an assessment-to-teaching device	1	2	3	4	5	6
9. Evaluates capacity to monitor performance with a variety of disabilities	1	2	3	4	5	6
10. Evaluates developmental appropriateness of materials	1	2	3	4	5	6
11. Evaluates adequacy of established criterion levels	1	2	3	4	5	6
12. Evaluates program for generalization and maintenance	1	2	3	4	5	6
13. Evaluates functional alternatives	1	2	3	4	5	6
14. Evaluates utility in natural environments	1	2	3	4	5	6
15. Integrates all the above information into overall critique of curriculum's benefits and drawbacks	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Child Intervention Programs
13 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Identifies appropriate objectives based on assessment information	1	2	3	4	5	6
2. Analyzes objective into smaller steps	1	2	3	4	5	6
3. Identifies criteria for success of objective including generalization	1	2	3	4	5	6
4. Identifies procedures for measuring objective	1	2	3	4	5	6
5. Obtains a baseline for performance	1	2	3	4	5	6
6. Plans and presents intervention based on assessment and implementation within the natural routine and/or play	1	2	3	4	5	6
7. Plans and implements positioning needs of child for optimal interaction	1	2	3	4	5	6
8. Plans and implements pacing based on assessment	1	2	3	4	5	6
9. Plans and implements closure of activity based on child's activity level	1	2	3	4	5	6
10. Determines strategies for generalization and maintenance	1	2	3	4	5	6
11. Determines strategies for parent involvement (observing, doing)	1	2	3	4	5	6
12. Determines strategies to implement in daily routines	1	2	3	4	5	6
13. Utilizes materials that are naturally within the intervention environment	1	2	3	4	5	6
14. Ensures the family understands the program	1	2	3	4	5	6

Please use the space on the back to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Intervention Delivery
14

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Environmental Planning						
1. Sets up the environment to support participation of all, children and parents	1	2	3	4	5	6
2. Plans the integration of all the objectives into the activity	1	2	3	4	5	6
3. Adheres to the child's schedule	1	2	3	4	5	6
4. Prepares data sheet that can be easily used during intervention	1	2	3	4	5	6
Implementation						
5. Discusses with parents the intervention activity and its purpose prior to engaging with the child	1	2	3	4	5	6
6. Allows warm up time for child before interaction	1	2	3	4	5	6
7. Encourages parent participation as much as parent wishes	1	2	3	4	5	6
8. Integrates engagement into activity	1	2	3	4	5	6
9. Positions child for optimal interaction	1	2	3	4	5	6
10. Facilitates peer interaction	1	2	3	4	5	6
11. Uses incidental teaching to promote objective acquisition	1	2	3	4	5	6
12. Uses language that child understands as well as facilitates to his/her next level	1	2	3	4	5	6
13. Adapts activity as needed for optimal success	1	2	3	4	5	6
14. Individualizes cues and reinforcers	1	2	3	4	5	6

(Continued on back)

15. Maintains child's motivation by responding to cues	1	2	3	4	5	6
16. Models appropriate behaviors	1	2	3	4	5	6
17. Explains to parents child's performance (strength-based) as activity progresses	1	2	3	4	5	6
18. Interacts with all children during the activity	1	2	3	4	5	6
19. Collects data throughout the activity	1	2	3	4	5	6
20. Uses appropriate prompts (models, physical assistance, verbal prompts)	1	2	3	4	5	6
21. Allows the child to make choices throughout the activity	1	2	3	4	5	6
22. Communicates effectively with parents	1	2	3	4	5	6
23. Incorporates functional routines into activities	1	2	3	4	5	6
24. Uses natural cues and consequences	1	2	3	4	5	6
25. Modifies activity for child to complete independently	1	2	3	4	5	6
26. Facilitates family participation by providing mechanisms for families to integrate into natural routines	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Intervention Procedures
15

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Utilizes developmentally appropriate practice	1	2	3	4	5	6
2. Utilizes interventions that result in the child's awareness and recognition of their own capacities and his/her influence on objects and people	1	2	3	4	5	6
3. Conducts intervention in the context of daily occurring routines	1	2	3	4	5	6
4. Encourages child to initiate activities	1	2	3	4	5	6
5. Ensures generalization of skill acquisition	1	2	3	4	5	6
6. Maximizes child's curiosity and desire to learn	1	2	3	4	5	6
7. Uses child-caregiver dyad as a context of learning	1	2	3	4	5	6
8. Utilizes a variety of presentation formats	1	2	3	4	5	6
9. Identifies and implements milieu strategies (incidental teaching, mand-model, modeling, naturalistic time delay) to be used in intervention	1	2	3	4	5	6
10. Identifies "back-up" strategies to be used in intervention	1	2	3	4	5	6
11. Elaborates child's behavior by providing models, restating vocalizations, suggesting alternatives, and open ended questions	1	2	3	4	5	6
12. Identifies and implements appropriate prompting strategies (constant and progressive time delay, system of least prompt, simultaneous prompting, most to least prompts, graduated guidance)	1	2	3	4	5	6
13. Identifies strategies for fading prompts	1	2	3	4	5	6

(Continued on back)

14. Uses natural reinforcement cues, schedules and techniques 1 2 3 4 5 6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Assistive Technology (low tech)
16 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:
6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Identifies appropriate child for assistive technology need	1	2	3	4	5	6
2. Coordinates assistive technology assessment for the family	1	2	3	4	5	6
3. Participates in assistive technology assessment by providing information on the child and family's resources, priorities and concerns	1	2	3	4	5	6
4. Compiles information on assistive technology device needed	1	2	3	4	5	6
5. Integrates assistive technology into IFSP objectives	1	2	3	4	5	6
6. Ensures assistive technology increases the child's functional skills	1	2	3	4	5	6
7. Ensures assistive technology can be implemented in natural environments and routines	1	2	3	4	5	6
8. Ensures assistive technology increases the child's independence	1	2	3	4	5	6
9. Ensures the family can easily utilize the assistive technology in daily routines	1	2	3	4	5	6
10. Ensures assistive technology increases child's ability to interact with typical peers	1	2	3	4	5	6
11. Evaluates efficacy of assistive technology program	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Assistive Technology (high tech)
16 (2 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Identifies appropriate child for assistive technology need	1	2	3	4	5	6
2. Coordinates assistive technology assessment for the family	1	2	3	4	5	6
3. Participates in assistive technology assessment by providing information on the child and family's resources, priorities and concerns	1	2	3	4	5	6
4. Explores low tech options to achieve objectives	1	2	3	4	5	6
5. Compiles information on assistive technology device needed	1	2	3	4	5	6
6. Integrates assistive technology into IFSP objectives	1	2	3	4	5	6
7. Ensures assistive technology increases the child's functional skills	1	2	3	4	5	6
8. Ensures assistive technology can be implemented in natural environments and routines	1	2	3	4	5	6
9. Ensures assistive technology increases the child's independence	1	2	3	4	5	6
10. Ensures the family can easily utilize the assistive technology in daily routines	1	2	3	4	5	6
11. Ensures assistive technology increases child's ability to interact with typical peers	1	2	3	4	5	6
12. Evaluates efficacy of assistive technology program	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Handling, Lifting & Carrying
17

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Evaluates the child's movements (both abilities and concerns) and tone prior to handling	1	2	3	4	5	6
2. States information to consider prior to handling, including family concerns	1	2	3	4	5	6
3. Slowly paces the handling and carrying procedure to give the child time to adapt	1	2	3	4	5	6
4. Normalizes tactile, proprioceptive and kinesthetic input	1	2	3	4	5	6
5. Handles, lifts and carries child in a way that avoids abnormal compensatory movements	1	2	3	4	5	6
6. Handles, lifts and carries child in a way that promotes normal movement patterns	1	2	3	4	5	6
7. Allows the child to gradually take over some active movement	1	2	3	4	5	6
8. Carries child in a way that allows the child to explore his/her environment to the maximum extent possible	1	2	3	4	5	6
9. Communicates techniques to family in an understandable manner	1	2	3	4	5	6
10. Communicates reasons behind techniques to family in an understandable manner	1	2	3	4	5	6
11. Ensures family understands techniques and rationale by asking to rephrase, practice with supervision and soliciting questions	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Positioning
18

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Positioning: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Evaluates the child's movements (both abilities and concerns) and tone prior to handling	1	2	3	4	5	6
2. States information to consider prior to handling including family concerns	1	2	3	4	5	6
3. Slowly paces the positioning procedure to give the child time to adapt	1	2	3	4	5	6
4. Normalizes tactile, proprioceptive and kinesthetic input	1	2	3	4	5	6
5. Positions child in a way to inhibit abnormal reflexes and movement	1	2	3	4	5	6
6. Positions child in a way that promotes normal movement patterns	1	2	3	4	5	6
7. Allows the child to take over the active movement gradually	1	2	3	4	5	6
8. Positions child in a way to maximize exploration of the environment	1	2	3	4	5	6
9. States the appropriate length of time the child should be in the position	1	2	3	4	5	6
10. Communicates techniques to family in an understandable manner	1	2	3	4	5	6
11. Communicates reasons behind techniques to family in an understandable manner	1	2	3	4	5	6
12. Uses adaptive equipment to facilitate positioning						
13. Individualizes equipment for child						

(Continued on back)

14. Ensures family understands techniques and rationale by asking to rephrase, practice with supervision and asking questions	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Feeding
19 (1 of 2)

Participant: ______________________________ Date: ______________________________

Supervisor/Mentor: ______________________________ Setting: ______________________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Assessment						
1. Gathers information on feeding routine	1	2	3	4	5	6
2. Observes a family member or therapist feeding	1	2	3	4	5	6
3. If appropriate, conducts an oral motor exam	1	2	3	4	5	6
4. Advocates for any additional feeding assessments necessary (i.e. video fluoroscopy)	1	2	3	4	5	6
Intervention						
5. Prepares infant/toddler for feeding	1	2	3	4	5	6
6. Prepares space for feeding	1	2	3	4	5	6
7. Positions the child for feeding	1	2	3	4	5	6
8. Inhibits abnormal patterns and reflexes	1	2	3	4	5	6
9. Uses/adapts equipment for optimal positioning	1	2	3	4	5	6
10. Elicits interaction/communication from infant/toddler	1	2	3	4	5	6
11. Embeds feeding program into family routine	1	2	3	4	5	6
12. Provides family with explanation of intervention and justification throughout entire intervention	1	2	3	4	5	6
13. Ensures family understands feeding techniques, rationale	1	2	3	4	5	6
14. Ensures family can implement techniques as demonstrated by supervised practice	1	2	3	4	5	6
15. Designs data collection to monitor feeding program	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Social Competence
20 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Assessment

1. Gathers information from multiple sources and occasions regarding the child's social competence using the Assessment of Peer Relations	1	2	3	4	5	6
2. Identifies outcomes and objectives based on the assessment information	1	2	3	4	5	6
3. Communicates assessment findings to family and community staff	1	2	3	4	5	6

Intervention

4. Designs an intervention plan that integrates social competence objectives and other developmental objectives into naturally occurring routines in natural environments	1	2	3	4	5	6
5. Communicates intervention plan to family and community staff to assist in implementing	1	2	3	4	5	6
6. Creates specific activities to address social competence skills using various levels of assistance	1	2	3	4	5	6
7. Implements social competence intervention appropriately through either direct service or consultation with community staff and family	1	2	3	4	5	6
8. Extends the child's social interactions through clarification, suggestions, etc.	1	2	3	4	5	6
9. Designs and utilizes data collection procedure to monitor intervention	1	2	3	4	5	6
10. Makes recommendations for modification as needed based on observations and data collection	1	2	3	4	5	6
11. Ensures family understands importance of social competence and interventions	1	2	3	4	5	6

Please use the space on the back to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Sleeping Issues
21 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ____________________ Setting: ____________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Assessment

1. Gathers information through parent interview on the sleeping issue and routine of child and family (naptime, feeding, bedtime routine)	1	2	3	4	5	6
2. Designs data collection to be implemented by the family to determine a baseline of sleeping habits	1	2	3	4	5	6
3. Explores possible medical or other underlying causes to the sleeping issue	1	2	3	4	5	6
4. Identifies outcomes and objectives for intervention with regard to sleep	1	2	3	4	5	6

Intervention

5. Designs sleep program in collaboration with family	1	2	3	4	5	6
6. Consults with family to implement sleep program	1	2	3	4	5	6
7. Ensures family understands the program by asking to rephrase plan, asking questions, practicing steps	1	2	3	4	5	6
8. Provides an alternative plan with a criteria cutoff of when to implement alternative	1	2	3	4	5	6
9. Designs data collection plan that is easy to use by the family	1	2	3	4	5	6
10. Discusses and adapts the intervention plan at each visit	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Behavior Issues
22 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Assessment						
1. Explains to the family the assessment and intervention process of behavior programs	1	2	3	4	5	6
2. Gathers information through parent interview and observations on behavioral issues, routine of family and family's current intervention techniques	1	2	3	4	5	6
3. Designs data collection that the family can implement to determine antecedent, behavior and consequences of unwanted behavior	1	2	3	4	5	6
4. Explores possible medical or other underlying causes to the behavioral issue	1	2	3	4	5	6
5. Explores possible environmental issues contributing to the behavior	1	2	3	4	5	6
6. Identifies outcomes and objectives for intervention in collaboration with family	1	2	3	4	5	6
Intervention						
7. Designs behavioral program in collaboration with the family	1	2	3	4	5	6
8. Consults with family, including modeling, to implement behavioral intervention	1	2	3	4	5	6
9. Ensures family understands the program by asking to rephrase plan, asking questions and practicing steps	1	2	3	4	5	6
10. Provides an alternative plan with a criteria cutoff when to implement the alternative	1	2	3	4	5	6
11. Designs data collection plan easy for the family to use	1	2	3	4	5	6
12. Discusses and adapts the plan at each visit	1	2	3	4	5	6

Please use the space on the back to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Environmental Inventory
23

Participant: ____________________ Date: ____________________

Supervisor/Mentor: ____________________ Setting: ____________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Familiarizes self with the ITERS to administer with ease	1	2	3	4	5	6
2. Identifies strengths and limitations of the ITERS	1	2	3	4	5	6
3. Explains fully the rationale for implementing the ITERS	1	2	3	4	5	6
4. Scores each item based on the definition given in the manual	1	2	3	4	5	6
5. Cites specific examples for each score as justification	1	2	3	4	5	6
6. Phrases questions in an open-ended, factual manner	1	2	3	4	5	6
7. Scores furnishings and displays for children based on exactly what it seen and reported	1	2	3	4	5	6
8. Scores personal care routines based on what is exactly seen and reported	1	2	3	4	5	6
9. Spends adequate amount of time to observe and score listening and talking scale	1	2	3	4	5	6
10. Spends adequate amount of time to observe and score learning activities scale	1	2	3	4	5	6
11. Spends adequate amount of time to observe and score interaction scale	1	2	3	4	5	6
12. Scores program structure based on what is exactly seen and reported	1	2	3	4	5	6
13. Scores adult needs based on what is exactly seen and reported	1	2	3	4	5	6
14. Communicates results and recommendations in a sensitive and manner to day care staff and family	1	2	3	4	5	6

(Continued on back)

15. Interprets items on a protocol into general, functional skills	1	2	3	4	5	6
16. Provides families with a sense of empowerment instead of failure	1	2	3	4	5	6

Please use the space below to provide any comments of cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Environmental Adaptations
24 (1 of 2)

Participant: ______________________________ Date: ______________________________

Supervisor/Mentor: __________________________ Setting: __________________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Assesses the environment in an objective manner	1	2	3	4	5	6
2. Determines if objectives could be supported by adapting the environment (e.g.: increasing independence, decreasing sensory stimulation)	1	2	3	4	5	6
3. Collaborates with the family and daycare staff (if appropriate) during assessment and adaptations	1	2	3	4	5	6
4. Uses effective communication skills in making recommendations and rationale	1	2	3	4	5	6
5. Creates adaptations that are easy to implement in the specified environment	1	2	3	4	5	6
6. Creates adaptations that will assist the child in achieving a developmental objective	1	2	3	4	5	6
7. Provides family choices of different adaptations to achieve the same objective	1	2	3	4	5	6
8. Implements adaptation to the extent the family/day care approves	1	2	3	4	5	6
9. Uses adult learning principles to ensure family and day care understand rationale for adaptation	1	2	3	4	5	6
10. Designs data collection to measure success of implementation	1	2	3	4	5	6
11. Designs data collection to measure success of adaptation	1	2	3	4	5	6

Please use the space on the back of this page to provide any comments or cite specific examples of the above skill:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Scheduling
25

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Space						
1. Sets up the environment separating noisy and quiet areas	1	2	3	4	5	6
2. Defines each area using shelves, tables or tape	1	2	3	4	5	6
3. Displays materials at a height accessible to children	1	2	3	4	5	6
4. Logically places interest areas near needed resources	1	2	3	4	5	6
5. Incorporates traffic pattern that keeps children from constantly interrupting each other	1	2	3	4	5	6
6. Designs developmentally appropriate areas based on sensory play	1	2	3	4	5	6
Scheduling						
7. Balances active and quiet times	1	2	3	4	5	6
8. Balances group and individual times	1	2	3	4	5	6
9. Balances free and structured times taking into consideration developmentally appropriate practice	[illegible]	2	3	4	5	6
10. Specifies duration of intervention within activities	1	2	3	4	5	6
11. Delineates a routine plan and sufficient time for transitions	1	2	3	4	5	6
12. Allows flexibility in scheduling	1	2	3	4	5	6
13. Takes into account the age of the children, number of adult, and length of program in scheduling	1	2	3	4	5	6
Service Personnel						
14. Identifies staff responsibilities for each activity	1	2	3	4	5	6

(Continued on back)

15. Identifies each child's objectives for each activity						
16. Encourages staff to interact with all children in the group	1	2	3	4	5	6
Active participation						
17. Provides choices for children increasing investment	1	2	3	4	5	6
18. Selects activities that can encompass a wide variety of skill levels	1	2	3	4	5	6
19. Adapts activities as necessary for participation of all children	1	2	3	4	5	6
Learning objectives						
20. Integrates all developmental domains into activities and objectives	1	2	3	4	5	6
21. Includes strategies for meaningful interactions with typical peers during activities	1	2	3	4	5	6
22. Allows children to select activities and materials	1	2	3	4	5	6
23. Provides for success in objectives	1	2	3	4	5	6
24. Uses developmentally appropriate and functional materials	1	2	3	4	5	6
Communication						
25. Includes regular meetings of all relevant personnel	1	2	3	4	5	6
26. Includes consultation to group team members as necessary	1	2	3	4	5	6
27. Uses a variety of ongoing communication procedures with parents	1	2	3	4	5	6
Data Collection						
28. Designs data collection procedures and collects data throughout the group time	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Reflection Checklist
NICU Observation
26

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ NICU: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Gathers complete medical background of infant being observed	1	2	3	4	5	6
2. Gathers complete current medical status of infant being observed	1	2	3	4	5	6
3. Gathers complete current medical treatments including mode of breathing and feeding	1	2	3	4	5	6
4. Describes fully autonomic signals (stress and abilities)	1	2	3	4	5	6
5. Describes fully motoric signals (stress and abilities)	1	2	3	4	5	6
6. Describes fully state (range and regulation)	1	2	3	4	5	6
7. Describes fully interactional capacity and stress signals	1	2	3	4	5	6
8. Describes developmental interventions used in the NICU regarding stress, self-regulation, interaction and positioning	1	2	3	4	5	6
9. Recommends additional interventions to assist in development	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Compilation Checklist
Genetic/Medical Conditions
27 (1 of 2)

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Genetic/Medical Condition: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Identifies possible etiologies for medical/genetic conditions compiled through multiple sources	1	2	3	4	5	6
2. Lists the symptoms and physical characteristics of the condition	1	2	3	4	5	6
3. Describes the current interventions the child is receiving both medically and developmentally	1	2	3	4	5	6
4. Describes the current interventions the family is receiving	1	2	3	4	5	6
5. Describes additional interventions that may assist the child and family	1	2	3	4	5	6
6. Delineates adaptations to intervention to promote health and competence	1	2	3	4	5	6
7. Communicates information to family in a concise, sensitive manner that is easily understood	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Information Checklist
Seizures & Medications
28

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Seizure Disorder: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Describes procedures used for diagnosing a seizure disorder	1	2	3	4	5	6
2. Identifies medications prescribed for seizure management	1	2	3	4	5	6
3. Explores contraindications and side effects of medications	1	2	3	4	5	6
4. Describes and executes procedures to follow during a seizure	1	2	3	4	5	6
5. Designs documentation to record and monitor seizures	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Plan Checklist
Home Health Care
29

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Compiles medical history and stability of the child	1	2	3	4	5	6
2. Interviews family to determine resources, priorities and concerns	1	2	3	4	5	6
3. Interviews family to determine daily routine and the implications of medical needs in the routine's structure	1	2	3	4	5	6
4. Adheres to medications, dosage, time for administration	1	2	3	4	5	6
5. Identifies any equipment needs, their function and implementation in daily routine	1	2	3	4	5	6
6. Integrates health and developmental needs into daily routine	1	2	3	4	5	6
7. Integrates heath and developmental needs into outcomes and implementation	1	2	3	4	5	6
8. Creates home health plan that is easily understood and as simple as possible for the family	1	2	3	4	5	6
9. Designs data collection and charting system to track medical routine, changes and qualitative comments	1	2	3	4	5	6
10. Designs communication system among health care workers, interventionists and family	1	2	3	4	5	6
11. Designs time for team communication	1	2	3	4	5	6
12. Delineates roles for decision making and responsibilities for tasks	1	2	3	4	5	6
13. Adheres to health and safety regulations	1	2	3	4	5	6

Please use back page to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist

Transition/Discharge Planning

30

Participant: ______________________________ Date: ______________________________

Supervisor/Mentor: ______________________ Sending/Receiving Agency: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Creates a flexible system that can be tailored to each family	1	2	3	4	5	6
2. Includes steps to identify family's resources, priorities and concerns in relation to the next environment	1	2	3	4	5	6
3. Includes a variety of options for starting a transition plan	1	2	3	4	5	6
4. Includes a variety of next environment options for the family	1	2	3	4	5	6
5. Collaborates with sending/receiving agency to ensure proper documentation and requirements are followed	1	2	3	4	5	6
6. Collaborates with sending/receiving agency to ensure family's resources, priorities and concerns are supported	1	2	3	4	5	6
7. Addresses confidentiality issues	1	2	3	4	5	6
8. Includes a variety of communication modes to ensure understanding from all parties	1	2	3	4	5	6
9. Identifies specific roles and responsibilities of sending and receiving agencies	1	2	3	4	5	6
10. Provides the family with basic information in a variety of mediums of service provision of sending and receiving agencies	1	2	3	4	5	6
11. Ensures the plan is consistent with family resources, priorities and concerns	1	2	3	4	5	6
12. Ensures the plan has administrative support from both sending and receiving agencies	1	2	3	4	5	6

Please use the back page to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Consultation
31

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Discusses with team the concern identified	1	2	3	4	5	6
2. Becomes fully aware of child's strengths and concerns and family's resources, priorities and concerns, either through interview, observation, or direct contact	1	2	3	4	5	6
3. If direct contact with the child or family, allows time for child and family to get acquainted with consultant before interviewing or having hands-on contact with child	1	2	3	4	5	6
4. Provides consultation to team members regarding area of concern by modeling, verbal recommendations; followed by rationale	1	2	3	4	5	6
5. Utilizes adult learning principles during both information gathering and consultation phase	1	2	3	4	5	6
6. Utilizes effective communication skills during both information gathering and consultation phase	1	2	3	4	5	6
7. Ensures family understands recommendations and can carry over through practice, rephrasing strategy or asking questions	1	2	3	4	5	6
8. Provides team members with summary of recommendation and rationale to refer to	1	2	3	4	5	6
9. Provides team members with appropriate times to question the need for additional consultation	1	2	3	4	5	6
10. Provides a specific time for follow-up to consultation	1	2	3	4	5	6
11. Communicates all aspects of recommendations in a thorough manner to ensure carryover ability	1	2	3	4	5	6

Please use the back of the page to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist

State and Federal Regulations

32

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Describes legislative implications for confidentiality	1	2	3	4	5	6
2. Describes legislative implications for assessment	1	2	3	4	5	6
3. Describes legislative implications for record keeping	1	2	3	4	5	6
4. Describes legislative implications for service delivery options	1	2	3	4	5	6
5. Describes legislative implications for parent participation	1	2	3	4	5	6
6. Describes legislative implications for individual programming	1	2	3	4	5	6
7. Describes legislative implications for interaction with typical peers	1	2	3	4	5	6
8. Describes legislative implications for conflict resolution	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Communicating Role and Knowledge
33

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Prepares statement of objectives	1	2	3	4	5	6
2. Prepares an agenda of training	1	2	3	4	5	6
3. Prepares training procedures, methods and materials	1	2	3	4	5	6
4. Prepares statement of performance criteria	1	2	3	4	5	6
5. Uses adult learning principles in training	1	2	3	4	5	6
6. Uses effective communication skills	1	2	3	4	5	6
7. Respects input of participants	1	2	3	4	5	6
8. Provides a mechanism for feedback	1	2	3	4	5	6
9. Provides a mechanism for evaluation of training	1	2	3	4	5	6
10. Provided information that is relevant and immediately applicable to participants	1	2	3	4	5	6
11. Describes role changes based on setting	1	2	3	4	5	6
12. Discussed range and variability of developmental concepts	1	2	3	4	5	6
13. Adapts training based on participant's input, training and interests	1	2	3	4	5	6
14. Discusses the integration of developmental domains	1	2	3	4	5	6
15. Comprehensively covers major functions of discipline	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Product Checklist
Community Services
34

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

Resources File						
1. Identifies additional information necessary for existing resources	1	2	3	4	5	6
2. Attains additional information for completeness of the resource	1	2	3	4	5	6
3. Identifies 5 additional resources absent from the file that would be appropriate for families of young children	1	2	3	4	5	6
4. Obtains comprehensive information on the resources	1	2	3	4	5	6
Community Map						
5. Compiles information on the family's resources, priorities and concerns	1	2	3	4	5	6
6. Determines possible resources in the community	1	2	3	4	5	6
7. Cross references family preferences to available community resources	1	2	3	4	5	6
8. Considers costs, transportation issues and family's daily routine	1	2	3	4	5	6
9. Provides the family with at least 2 community choices to achieve their desired outcomes	1	2	3	4	5	6
10. Creates a plan for the family to obtain the chosen community resource	1	2	3	4	5	6
11. Supports the family in accessing the identified community resource	1	2	3	4	5	6
12. Designs and implements an evaluation plan for the success of the objective and the appropriateness of the community resource	1	2	3	4	5	6

Please use the space on the back to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Project Checklist
Interagency Collaboration
35

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Collaborative Agency: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Scans the service region for a partnership significant in providing comprehensive Birth to Three services	1	2	3	4	5	6
2. Creates a plan to introduce the agency to the collaborative agency	1	2	3	4	5	6
3. Communicates agency's role and responsibility as a Birth to Three provider to the collaborative agency	1	2	3	4	5	6
4. Identifies and communicates the benefits to collaboration for each agency	1	2	3	4	5	6
5. Identifies and communicates benefits to collaboration for all families involved	1	2	3	4	5	6
6. Clearly identifies objectives of the collaboration	1	2	3	4	5	6
7. Outlines plan of collaboration	1	2	3	4	5	6
8. Clearly identifies roles and responsibility of each agency	1	2	3	4	5	6
9. Implements partnership	1	2	3	4	5	6
10. Evaluates partnership for success of objectives and appropriateness of partnership	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Product Checklist
Program Philosophy
36

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:
6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Creates/Reviews a program philosophy addressing child development that is consistent with federal and state legislation, best practices of early intervention and administrative functioning	1	2	3	4	5	6
2. Creates/Reviews a program philosophy addressing family development that is consistent with federal and state legislation, best practices of early intervention and administrative functioning	1	2	3	4	5	6
3. Comprehensively defines service delivery	1	2	3	4	5	6
4. Creates/Reviews a program philosophy addressing service delivery that is consistent with federal and state legislation, best practices of early intervention and administrative functioning	1	2	3	4	5	6
5. Clearly defines transdisciplinary teaming and philosophy	1	2	3	4	5	6
6. Creates/Reviews a program philosophy addressing transdisciplinary teaming that is consistent with federal and state legislation, best practices of early intervention and administrative functioning	1	2	3	4	5	6
7. Identifies strategies to disseminate philosophy to staff and embed philosophy in all areas of agency operation	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Observation Checklist
Service Delivery
37

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Creates program philosophy (as rated in competency #30)	1	2	3	4	5	6
2. Designs plan for orienting families to early intervention and agency	1	2	3	4	5	6
3. Designs plan for orienting staff to early intervention and agency	1	2	3	4	5	6
4. Identifies community resources beneficial for linkage	1	2	3	4	5	6
5. Creates a plan to introduce agency to community	1	2	3	4	5	6
6. Proposes child find plan appropriate for population in stated region	1	2	3	4	5	6
7. Proposes screening plan appropriate for region and capable by agency (with linkages)	1	2	3	4	5	6
8. Designs evaluation and assessment procedures to be followed for early intervention referrals	1	2	3	4	5	6
9. Allows for flexibility in assessment procedures	1	2	3	4	5	6
10. Designs plan for curriculum development and evaluation in intervention	1	2	3	4	5	6
11. Creates a variety of placement options in line with legislation and best practice	1	2	3	4	5	6
12. Delineates scope of services in early intervention	1	2	3	4	5	6
13. Delineates staffing patterns for agency	1	2	3	4	5	6
14. Identifies plan for staff development including requirements, options and agency/staff responsibilities	1	2	3	4	5	6

AIIM

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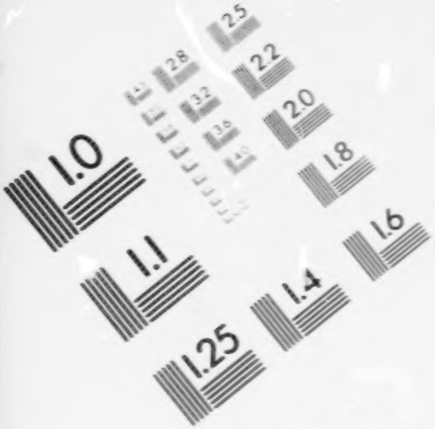
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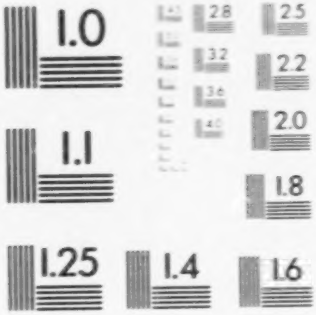
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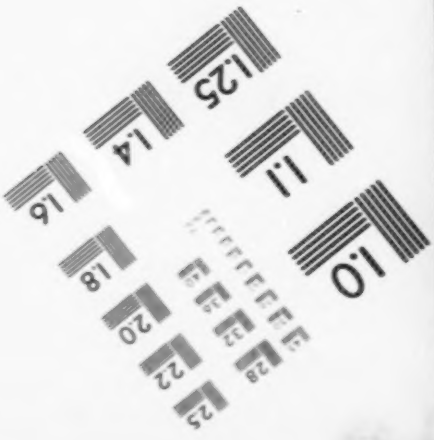
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BY APPLIED IMAGE, INC.

(Continued on back)

15. Designs evaluation plan that includes each aspect of service delivery	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Reflection Checklist
Southbury Training School
38

Participant: ______________________ Date: ______________________
Rater: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Identified and commented on quality of life indicators	1	2	3	4	5	6
2. Addressed early intervention's role in reducing the likelihood of institutionalization	1	2	3	4	5	6
3. Described adherence to principles of family centered care with a rationale	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Project Checklist
Advocacy Project
39

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Setting: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Clearly identifies advocacy subject	1	2	3	4	5	6
2. Clearly identifies objectives of advocacy project	1	2	3	4	5	6
3. Gathers information on advocacy topic	1	2	3	4	5	6
4. Outlines plan of action for advocacy	1	2	3	4	5	6
5. Identifies strategies for implementation of project	1	2	3	4	5	6
6. Adapts strategies as obstacles arise	1	2	3	4	5	6
7. Keeps records of minutes of meetings towards meeting objectives	1	2	3	4	5	6
8. Evaluates final decision in advocacy project	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Evaluation Checklist
Teaching a Class
40

Participant: ______________________ Date: ______________________

Supervisor/Mentor: ______________________ Curriculum: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Understood and developed a knowledge base on the subject matter chosen to be presented to classmates.	1	2	3	4	5	6
2. Utilized a team approach when collaborating with classmates to developing topic, materials and presentation for class.	1	2	3	4	5	6
3. Planned, organized and developed presentation and materials in an agenda and bibliography format.	1	2	3	4	5	6
4. Prepared class activities and references relevant to the subject matter presented.	1	2	3	4	5	6
5. Allowed for entire team to participate in presentation to class.	1	2	3	4	5	6
6. Presented subject matter in a clear, concise and understandable way	1	2	3	4	5	6
7. Provided time for classmate's participation in question and answer period.	1	2	3	4	5	6
8. Respected others viewpoints within the class discussion of topic.	1	2	3	4	5	6
9. Developed a self evaluation process to assess one's knowledge of subject matter and response of entire class to presentation and references on topic.	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Early Intervention Specialist Program
Division of Child and Family Studies
UCONN Health Center

Evaluation Checklist
Mentoring
41

Participant: ______________________________ Date: ______________________

Supervisor/Mentor: ______________________________ Curriculum: ______________________

Please rate the participant's performance on each of the following criteria. Use the following scale:

6 = Excellent
5 = Area of strength
4 = Competent
3 = Acceptable
2 = Area to improve
1 = Unsatisfactory

1. Expectations of both parties are articulated at the beginning of the relationship during a pre-conference meeting.	1	2	3	4	5	6
2. Needs were assessed and objectives of competency were established in a collaborative manner which resulted in a written action plan.	1	2	3	4	5	6
3. Mentor reviewed and gave positive feedback on objectives established prior to the implementation of the competency task.	1	2	3	4	5	6
4. Mentor assisted on problem solving, shared experiences and reflected on current best practices during competency performance.	1	2	3	4	5	6
5. Both mentor and mentee participated in the implementation process to expand and refine skills as outlined in the action plan.	1	2	3	4	5	6
6. Mentor and mentee allowed time for post conference to reflect on best practice and self evaluation.	1	2	3	4	5	6

Please use the space below to provide any comments or cite specific examples of the above skills:

Program Competency Evaluation Criteria - 1998

PROGRAM COMPETENCY	1	2	3	4	5	6
Families						
1. Family Assessment to include: needs social supports functions daily routine adaptation coping	Have heard of them	Can name 1-2 protocols	#2 plus have participated in at least one	#3 plus can describe at least 3	#4 plus has planned and participated	#5 plus has done this regularly as primary care provider
2. Family Focused Interview - Agenda - Communication skills	Never observed one	Observed at least one	Participated in at least one	Planned agenda and participated in one	Planned, participated, evaluated at least one	Has done this regularly as primary care provider
3. Interview a family of cultural minority	Have no experience	Have knowledge of cultural minorities	Can develop an interview protocol for family	Demonstrates active listening skills	Communicates with family in simple language	#2-5 plus interviews at least one family of cultural minority
4. Daily routine of child first hand knowledge as primary care provider for an extended period of time (at least 6 hours)	Never spent time with child beyond own role, e.g., teacher or therapist	Never spent time with child beyond program boundaries	Have observed child in daily routine beyond program	#3 plus have spent time with child beyond program boundaries with other(s) in charge	#3 & 4 plus have spent at least 1 hour as primary care provider	#3, 4, & 5 plus have spent at least one day as primary care provider
5. Parent-child Interactional Assessment	No familiarity	Know of at least one instrument	Can describe the assessment process relating to at least one instrument	Can describe at least 2 different instruments	Have knowledge of at least 3 screening instruments with their implications	#5 plus have implemented at least one with a written report summary

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PROGRAM COMPETENCY	1	2	3	4	5	6
6. Assessment selection	Can name one assessment tool and why it is used	#1 plus can differentiate screening from assessment process	#2 plus can describe at least 2 tools for each and their effective use as part of a process	#3 plus can describe the process of screening and assessment	#4 plus can plan for and describe at least one tool used for each step from screening through follow-up evaluation	Can effectively describe the assessment techniques, purpose, and process from screening through follow-up evaluation
7. Developmental Assessment	Can name at least 1 developmental assessment	#1 plus can describe components, e.g.: - norming - scoring - implications	#2 plus can name a variety of tools	#3 plus have used at least one developmental or sensorimotor assessment but does not know the background info of tool	#4 plus have reviewed and administered at least 1 developmental or sensorimotor assessment with reported implications	#5 plus have reviewed and administered at least 3 developmental assessments a) used same process with 2 infants/toddlers, one with, one without disabilities b) used one sensori-motor assessment with child under 18 months and reported implications
8. Collaborative goal setting developed as part of a team (family and professionals) based on family's input re: needs for support, information and intervention	Never read family goals	Read family goals, never done them	Observed a team developing family goals at least once	#2 & 3 plus participated at least once in developing goals with family	Responsible for developing goals	#4 & 5 plus has done this regularly as primary care provider

PROGRAM COMPETENCY	1	2	3	4	5	6
9. Developing an IFSP based on the 7 components as defined by federal and state guidelines	Have "heard of" an IFSP	Can list 4-5 of the components	#2 plus can list 3 things that make IFSP different from IEP	#2 & 3 plus have observed an IFSP process, e.g., team meeting with parents	#2, 3, & 4 plus have participated in at least one IFSP development	#5 plus has done this regularly as primary care provider
10. Facilitation of an IFSP conference or staffing	Not sure what this implies	Can develop an agenda for such a meeting	#2 plus can recognize difference between multi- and trans-disciplinary approach	#2 plus can describe the difference between an inter- and trans-disciplinary approach	#4 plus have facilitated at least one IFSP conference	#5 plus written summary to include group process and evaluation of process and outcome
11. Family Service Delivery as planned in IFSP using an agenda with objectives, methods and resources to meet the objectives, and data collection to evaluate outcome	Not sure what this involves	Can develop an agenda with objectives	#2 plus can identify methods and resources and plan evaluation of outcome	#2 & 3 plus have observed at least one planning, implementation, and evaluation process	#2, 3, & 4 plus have participated in at least one planing, implementation, and evaluation	#5 plus has done this regularly as primary care provider
12. Curriculum evaluation	Not sure how to do this	Can name at least 5 evaluation criteria	Can name and describe at least 5 evaluation criteria	Can name and describe at least 10 evaluation criteria	#4 plus have evaluated 1 curricula using recommended format	#4 plus have evaluated at least 3 curricula using recommended format
13. Intervention plans	Not sure what all the components are	Can name 3 components	Can name and describe at least 3 components	Can name and describe all the components	#4 plus have participated in the development of an intervention plan	Has written at least 3 intervention plans delineating all the components

PROGRAM COMPETENCY	1	2	3	4	5	6
14. Intervention delivery	Not sure what this involves	Observed delivery at least once	Regular observation of delivery	Delivery with supervision	Independently demonstrated ability with individual, or small or large group	Demonstrated ability to implement intervention program with individual, small and large group
15. Intervention procedures	Not sure how one defines these procedures	Can define at least 3 types of procedures/ presentation formats	#2 plus can define types of reinforcement and levels of assistance	Can recognize the match between objectives, strategies and criteria	Can use a variety of strategies to match content, criteria, and conditions of objectives	#3, 4, & 5 plus can independently use a variety of strategies to match content, criteria, and conditions of objective with back up procedures
16. Adaptive equipment and prosthetic materials	Not sure what this means	Familiar with some of the rationale and terminology	Can describe rationale and types of adaptations	#3 plus have participated with team working on these concerns	#4 plus have carried out this mode of intervention at least once with supervision	#5 plus have consistently carried this out as primary care provider
17. Handling, lifting, and carrying infant/toddler with motor impairments	Not familiar with the rationale or components	Have observed at least once	Have regularly observed a competent handler	#3 plus knowledge of rationale and some of the components	#4 plus have done this along with competent personnel	#5 plus have consistently carried this out as primary care provider
18. Positioning of infant/toddler with motor impairments	Not sure what this implies	Can assess if positioning needs adaptation in at least one position	#2 in at least 3 positions	#3 plus have observed positioning in wide variety of situations	#4 plus can assess need for and plan intervention with supervision	#5 plus have consistently carried this out as primary care provider

PROGRAM COMPETENCY	1	2	3	4	5	6
19. Feeding	Not familiar with this area of intervention	Has heard of the issues involved	Can describe the necessary components of this intervention	#3 plus have regularly observed feeding intervention	#4 plus have assessed, planned and implemented feeding program for at least one infant/toddler with supervision	#5 plus have consistently carried this out as primary care provider
20. Social competence curriculum	Not familiar with Assessment of Peer Relations	Has heard of it	Has seen a copy and reviewed the protocol	Have used it once	Uses tool when appropriate	Can design intervention techniques on it and communicate to involved parties
21. Collection of data	Not sure how to collect	Can determine and collect baseline data	Can implement intervention plan on data	Can collect data after plan implemented	Can train others to implement	#2-5 plus can evaluate effectiveness of intervention
22. Sleeping/behavior issues	Not sure how to collect	Can determine and collect baseline data	Can implement intervention plan on data	Can collect data after plan implemented	Can train others to implement	#2-5 plus can evaluate effectiveness of intervention
23. Environmental Inventory	Not sure what this involves	Has heard of the ECERS or ITERS	Have seen a copy of ECERS or ITERS	Have reviewed the ITERS	#4 plus have seen the ITERS used	#5 plus have completed at least one ITERS in a center-based or day care setting
24. Environmental adaptation	Not sure what this involves	Can observe and assess one environment	Communicates info to parents	Can design adaptations with parents	Can implement adaptations with parents	#2-5 plus evaluate effectiveness of plan

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PROGRAM COMPETENCY	1	2	3	4	5	6
25. Scheduling a program for intervention based on IFSP	Not sure what this involves	Can delineate at least 2 of the components involved	Can delineate all the components involved	Can write a schedule from the perspective of one role	Can write a schedule from the perspective of two roles	Can write a plan for 8-12 infants/toddlers delineating all the components that effect scheduling
26. Neonatal Intensive Care Unit	Never been to one	Visited at least one	Can describe rationale and components of NICU infant report	#3 plus observed development of at least one NICU infant report	#4 plus participated in the development of one NICU infant report	#5 plus has done this regularly as primary care provider
27. Implications of exceptionalities and medical conditions	Not sure what this means	Familiar with the terms that name different conditions, but that's all	#2 plus knows the difference between genetic and medical conditions but not sure how to explain it	#2 plus can explain the difference between a genetic and medical condition	#2, 3,& 4 plus can briefly describe with sources at least one genetic and one medical condition with implications for development	#5 plus can give comprehensive description with sources of 2 genetic and 2 medical conditions
28. Seizures and medications	Cannot differentiate one type of seizure from another	Knows that seizure disorders vary but not sure how	Can name at least 5 kinds of seizure disorders and at least 3 types of medication	#3 plus can recognize at least 3 types of seizure disorders	#4 plus can describe one type of seizure disorder including diagnostic procedures, medications prescribed with contraindications and side effects; procedures used during seizure; documentation to monitor seizure	#4 plus 5 for at least 2 seizure disorders

PROGRAM COMPETENCY	1	2	3	4	5	6
29. Home Health Care	Don't know what this means	Have heard of this process	Can describe the rationale and components	#3 plus have participated in the development of at least 1	#3 & 4 plus have independently completed at least 1	#5 plus have independently completed at least 5
30. Transition and Discharge Planning	Never been in this process	Can name the necessary components	Can describe the law in relation to the components	#3 plus have observed the development of a transition plan	#4 plus have been involved in at least 2 or 3 components	Can develop a system employing record keeping, communication, staff responsibilities, and follow-up
31. Consultation	Never consulted to other professionals	Consulted individually not as team member	Consulted at least once as a team member	Know how to role release	#3 & 4 plus communicate knowledge effectively to team	Regularly actively participate as consultant in EI intervention plans
32. State and Federal Regulations	Can name the 2 major federal laws that relate to early intervention	Can name at least 3 components discussed in these laws	Can name and describe at least components	Can describe implications for at leas 2 of these components	Can describe implications for at least4 of these components	Can describe implication re: a) confidentiality b) assessment and placement options c) record keeping d) service delivery options e) parent participation f) individual programming g) interaction with non-disabled peers h) conflict resolution

PROGRAM COMPETENCY	1	2	3	4	5	6
33. Knowledge of professional roles	Not sure of the potential team members	Can name at least 5 members of a team in EI	#2 plus can name the most important member of the team	#3 plus can describe the role functions in at least one setting	#3 plus can describe the potential roles in at least two settings	Can describe the major functions of the potential team members/roles in a: a) NICU b) home-based program c) center-based program d) follow-up clinic
34. Community services	Not familiar with resources	Knows of some resources	Can name 6 community resources	Knows how to access resources	Accesses community resources and used in conjunction with intervention	Has developed a written community map/resources for families
35. Collaboration	Never has collaborated	Has created a plan for collaboration	Can identify and communicate benefits of collaboration	Has written a plan	Has implemented a plan	Has evaluated a written implemented plan
36. Program philosophy	Not sure what the components are	Can name at least 3 components	Can define at least 3 components	Can define at least 6 components	Can define all the components	Can write a plan using all the component parts
37. Service delivery	Not sure what the components are	Can name at least 3 components	Can define at least 3 components	Can define at least 6 components	Can define all the components	Can write a plan using all the component parts
38. Tour of Southbury Training School and/or community home setting	Have never visited one	Visited at least one	Can reflect on quality of life indicators	Has had hands-on experience of institutionalization	Knowledge of early interventionists' involvement to reduce institutionalization	Written summary of reflection of visit

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PROGRAM COMPETENCY	1	2	3	4	5	6
39. Advocacy project	Never actively participated	Have followed someone else's plan	Observed the development of an advocacy plan	#3 plus observed implementation	Developed an advocacy plan either alone or with team	#5 plus active participation in an advocacy project related to the quality or expansion of services with documentation
40. Teaching a class	Not sure where to begin	Can name at least 3 components for planning	Can plan for each of these components	Can develop resources and references	Can develop training materials	#4 & 5 plus implement and self evaluate a teaching session
41. Mentorship	Never mentored	Understands the role of mentor	Documents mentorship plan	Implements plan with interventionist	Mentors one competency	Has implemented all mentorship criteria for evaluation

Competency Overall Rating Sheet

Early Intervention Specialist Program
UCONN Health Center Division of Child and Family Studies

NAME: ______________________________

SUPERVISOR: ______________________________

Date	Competency	Overall Rating	Initials Teacher Peer Mentor Agency Supervisor	for Completion University Supervisor
	1. Family Assessment			
	Observation Checklist	1 2 3 4 5 6		
	2. Family Interview			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	3. Interviewing a family representing a culturally or linguistically different heritage			
	Observation Checklist	1 2 3 4 5 6		
	4. Child Care			
	Family Checklist	1 2 3 4 5 6		
	5. Parent-Child Interaction Assessment			
	Observation Checklist	1 2 3 4 5 6		
	6. Child Assessment Selection			
	Observation Checklist	1 2 3 4 5 6		

	7. Child Developmental Assessment			
	Observation Checklist	1 2 3 4 5 6		
	8. IFSP Outcomes and Objectives			
	Observation Checklist	1 2 3 4 5 6		
	9. Individualized Family Service Plan			
	Observation Checklist	1 2 3 4 5 6		
	10. Facilitation of an IFSP Conference or Team Staffing			
	Observation Checklist	1 2 3 4 5 6		
	11. Family Service Delivery			
	Observation Checklist	1 2 3 4 5 6		
	12. Curriculum Evaluation			
	Evaluation Checklist	1 2 3 4 5 6		
	13. Child Intervention			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	14. Intervention Delivery			
	Observation Checklist	1 2 3 4 5 6		
	15. Intervention Procedures			
	Observation Checklist	1 2 3 4 5 6		
	16. Assistive Technology			
	Observation Checklist (low technology)	1 2 3 4 5 6		
	Observation Checklist (high technology)	1 2 3 4 5 6		
	17. Handling, Lifting and Carrying			
	Observation Checklist	1 2 3 4 5 6		

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	18. Positioning			
	Observation Checklist	1 2 3 4 5 6		
	19. Feeding			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	20. Integration of a social competence curriculum into intervention plan			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	21. Sleeping Issues			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	22. Behavior Issues			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	23. Environmental Inventory			
	Observation Checklist	1 2 3 4 5 6		
	24. Environmental Adaptations			
	Observation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	25. Scheduling			
	Observation Checklist	1 2 3 4 5 6		
	26. Neonatal Intensive Care Unit			
	Reflective Checklist	1 2 3 4 5 6		

	27. Implications of Genetic/Medical Conditions			
	Compilation Checklist	1 2 3 4 5 6		
	Family Checklist	1 2 3 4 5 6		
	28. Seizures and Medications			
	Information Checklist	1 2 3 4 5 6		
	29. Home Health Care			
	Plan Checklist	1 2 3 4 5 6		
	30. Transition and Discharge Planning			
	Observation Checklist	1 2 3 4 5 6		
	31. Consultation			
	Observation Checklist	1 2 3 4 5 6		
	32. State and Federal Regulations			
	Description Checklist	1 2 3 4 5 6		
	33. Communicating role and knowledge base			
	Observation Checklist	1 2 3 4 5 6		
	34. Community Services			
	Product Checklist	1 2 3 4 5 6		
	35. Interagency Collaboration			
	Project Checklist	1 2 3 4 5 6		
	36. Program Philosophy			
	Product Checklist	1 2 3 4 5 6		
	37. Service Delivery			
	Observation Checklist	1 2 3 4 5 6		

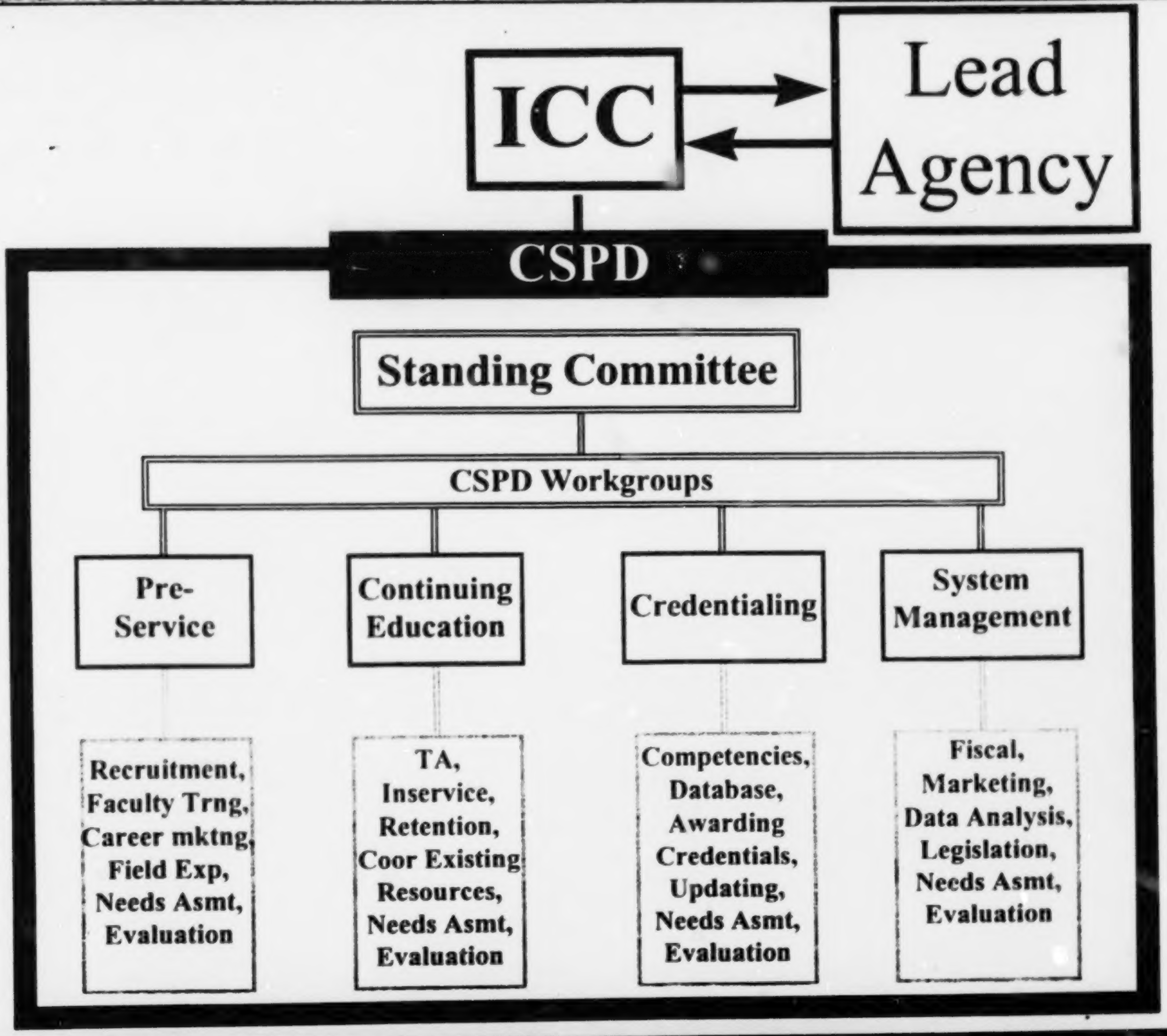
	38. Tour of Southbury Training School			
	Reflection Checklist	1 2 3 4 5 6		
	39. Advocacy Project			
	Project Checklist	1 2 3 4 5 6		
	40. Teaching a Class			
	Evaluation Checklist	1 2 3 4 5 6		
	41. Mentoring			
	Evaluation Checklist	1 2 3 4 5 6		

revised 1/8/98 as comrate

APPENDIX G

Comprehensive System of Personnel Development

To Have Good Things Happen for Children and Families



ICC

Lead Agency

CSPD

Standing Committee

CSPD Workgroups

Pre-Service
Recruitment, Faculty Trng, Career mktng, Field Exp, Needs Asmt, Evaluation

Continuing Education
TA, Inservice, Retention, Coor Existing Resources, Needs Asmt, Evaluation

Credentialing
Competencies, Database, Awarding Credentials, Updating, Needs Asmt, Evaluation

System Management
Fiscal, Marketing, Data Analysis, Legislation, Needs Asmt, Evaluation